

“UNDUE” DELEGATION: PRIVATE DELEGATION AND OTHER STRATEGIES TO CHALLENGE ADMITTING-PRIVILEGES LAWS

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INTRODUCTION

In November 2015, the Supreme Court granted certiorari to *Whole Woman's Health v. Cole*,¹ the first reproductive rights case to reach the court since *Gonzales v. Carhart*² eight years before. In the intervening time, states have passed an astonishing number of laws and regulations that encroach on women's access to abortion. Many such laws ostensibly aim to protect the woman and her fetus. Yet these same laws do so by imposing medically unnecessary and onerous procedural requirements on women,³ which can erect massive barriers to abortion access for individuals. Other state laws aim to regulate not the activities of women, but those of abortion providers, who are not a protected class. The reproductive rights movement terms these laws Targeted Regulations of Abortion Providers, or TRAP laws.⁴ State legislatures' passage of TRAP laws accelerated after the Supreme Court's

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1 *Whole Woman's Health v. Cole*, 790 F.3d 563 (5th Cir. 2015), *cert. granted*, 136 S. Ct. 499 (Nov. 13, 2015), *argued sub nom.* *Whole Woman's Health v. Hellerstedt*, No. 15-274 (Mar. 2, 2016).

2 *Gonzalez v. Carhart*, 550 U.S. 124 (2007).

3 Rachel Benson Gold & Elizabeth Nash, *TRAP Laws Gain Political Traction While Abortion Clinics—and the Women They Serve—Pay the Price*, 16 GUTTMACHER POL'Y REV. (Spring 2013), <http://www.guttmacher.org/pubs/gpr/16/2/gpr160207.html> [<http://perma.cc/3WZF-T2VM>].

4 See, e.g., GUTTMACHER INST., STATE POLICIES IN BRIEF: TARGETED REGULATIONS OF ABORTION PROVIDERS (Dec. 1, 2015), http://www.guttmacher.org/statecenter/spibs/spib_TRAP.pdf [<http://perma.cc/FFZ8-9Q8U>]; *Targeted Regulation of Abortion Providers (TRAP)*, CTR. FOR REPROD. RIGHTS (Aug. 28, 2015), <http://reproductiverights.org/en/project/targeted-regulation-of-abortion-providers-trap> [<http://perma.cc/7BMX-G5RH>]. Despite legislators' claims that these laws aim to protect women's safety, courts have recognized their stronger motive to make abortions unavailable. See, e.g., *Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 906, 912 (7th Cir. 2015) (“But the legislature’s intention to impose the two-day deadline, the effect of which would have been to force half the Wisconsin abortion clinics to close for months, is difficult to explain save as a method of preventing abortions that women have a constitutional right to obtain.”);

decision in *Carhart*, which was taken to signal judicial willingness to uphold state laws that aim to protect an unborn fetus at the expense of reducing a woman's ability to choose.⁵

This Note focuses on admitting-privileges laws, a type of TRAP law that requires physicians who provide abortions to obtain staff privileges at a hospital within a certain distance from their clinics. Without these required privileges, physicians performing abortions risk civil and criminal penalties. These laws are especially concerning because they give area hospitals an effective veto over a clinic's operations, effectively outsourcing the power to deny licenses to private entities. Admitting-privileges decisions are often discretionary for hospital administrators; a hospital's denial of admitting privileges also lacks state oversight or external appeals.

Admitting-privileges laws are being ratified throughout many states, but have proven resistant to traditional substantive due process challenges. In addition to traditional "undue burden" analysis, a multipronged approach to reproductive rights litigation and advocacy is necessary. Part I of this Note sets forth a brief history of the right to choose an abortion and the current federal legal framework. Then, it details recent state legislative and ballot initiatives aimed at regulating abortion providers. Part II explains the complications of using the "undue burden" doctrine in constitutional challenges to state action, as illuminated by recent cases litigating admitting-privileges laws. It further introduces private-delegation challenges as an alternative method to examine the constitutionality of these laws. Part III looks at the history of private-delegation challenges with respect to admitting-privileges laws and touches on other possible avenues to challenge admitting-privileges regulations.

I. Abortion in the Post-*Roe* Era

In 1973, the Supreme Court decided *Roe v. Wade*, which recognized that the Due Process Clause of the Fourteenth Amendment protects a right to privacy that extends to a woman's decision to have an abortion.⁶ *Roe*'s effect was remarkable. Before *Roe*, each individual state regulated abortions and the accessibility thereof with their traditional police powers. At the time of the decision, four states had repealed anti-abortion laws, while thirteen had begun reforms of their abortion laws.⁷ Almost all the rest banned abortion in most cases.⁸

5 *Carhart*, 550 U.S. 124. See also *infra* notes 146–49 and accompanying text.

6 *Roe v. Wade*, 410 U.S. 113 (1973).

7 *Id.* at 140 n.37.

8 *Id.* at 118.

After the Supreme Court identified a right to choose an abortion grounded in the federal Constitution, the annual number of legal abortions rose through the 1970s, leveling off in the 1980s.⁹ After *Roe*, the Supreme Court also decided *Doe v. Bolton*,¹⁰ which assessed the elaborate procedural barriers to abortion erected by the state of Georgia and invalidated some of them for being not reasonably related to the state interest¹¹ or redundant.¹² *Doe* has been interpreted to signal that “just as states may not prevent abortion by making the performance a crime, states may not make abortions unreasonably difficult to obtain by prescribing elaborate procedural barriers.”¹³

A. Relevant Federal Statutes and Regulations

Despite *Doe*’s warning, pro-life lobbyists have encouraged the passage of numerous federal statutory limits on abortion. First, Congress passed laws restricting the use of federal funds for elective abortions.¹⁴ Only four years after *Roe*, Congress passed the Hyde Amendment, banning the use of any federal funds for abortion absent a pregnancy that is the result of incest, rape, or that endangers the woman’s life.¹⁵ Because the law governs Medicaid spending, its effects are disproportionately felt among the poorest populations.¹⁶ Over the years, the reach of the Hyde Amendment has extended to limit the use of federal

9 Sarah Kliff, *Thirteen Charts that Explain How Roe v. Wade Changed Abortion Rights*, WASH. POST (Jan. 22, 2014), <http://www.washingtonpost.com/blogs/wonkblog/wp/2014/01/22/thirteen-charts-that-explain-how-ro-v-wade-changed-abortion-rights> [<http://perma.cc/6V2R-N7VB>].

10 *Doe v. Bolton*, 410 U.S. 179 (1973).

11 *Id.* at 194–95.

12 *Id.* at 197.

13 *See, e.g.*, JON O. SHIMABUKURO, CONG. RESEARCH SERV., RL33467, ABORTION: JUDICIAL HISTORY AND LEGISLATIVE RESPONSE 2 (2015).

14 *See* SHIMABUKURO, *supra* note 13, at 8–12. According to the Supreme Court, government failure to fund an abortion is not a restriction on the right to an abortion. *Maher v. Roe*, 432 U.S. 464, 464 (1977).

15 The Hyde Amendment is not a permanent law, but a rider routinely attached to annual appropriations bills since 1976. *See* Hyde Amendment Codification Act, S. 142, 113th Cong. (2013), <https://www.govtrack.us/congress/bills/113/s142/text> [<http://perma.cc/S6PC-ZDJT>]; Julie Rovner, *Abortion Funding Ban Has Evolved Over the Years*, NPR (Dec. 14, 2009, 2:25 PM), <http://www.npr.org/templates/story/story.php?storyId=121402281> [<http://perma.cc/R9A3-6V4H>].

16 Heather D. Boonstra, *The Heart of the Matter: Public Funding of Abortion for Poor Women in the United States*, GUTTMACHER POL’Y REV. (2007), <https://www.guttmacher.org/pubs/gpr/10/1/gpr100112.html> [<http://perma.cc/WKH4-Y7F2>].

funds for abortion for federal employees and women in the Indian Health Service.¹⁷

Congress also passed “conscience” laws, including the Church Amendments,¹⁸ which codify exemptions from any hypothetical federal requirement to provide abortions, if a hospital receiving certain federal funds or their employees object on the basis of religious or moral beliefs. Importantly, the Church Amendments also govern hospital personnel decisions. They prohibit any entity receiving money from certain federal entities from discriminating against any physician or other health care worker on the basis of their decision either to perform or abstain from performing an abortion.¹⁹

Over the years, Congress has also introduced more targeted legislation regulating elective abortions. Certain second trimester abortions are criminalized by the Partial-Birth Abortion Act of 2003²⁰—namely the procedure of intact dilation and extraction, or partial-birth abortion, upheld by the Supreme Court in 2007 and discussed *infra*.²¹ Most recently, the Patient Protection Affordable Care Act (PPACA)²² was passed into law, creating collateral consequences for access to abortion that largely preserved the status quo.²³ Under the PPACA, coverage for abortion services may not be required as part of the federally established essential benefits package.²⁴ Although private health plan providers

17 Alina Salganicoff et al., *Coverage for Abortion Services and the ACA*, KAISER FAM. FOUND. (Sept. 19, 2014), <http://kff.org/womens-health-policy/issue-brief/coverage-for-abortion-services-and-the-aca/> [<http://perma.cc/7GKY-GCBY>].

18 42 U.S.C. § 300a-7 (2012).

19 42 U.S.C. § 300a-7(c)(1).

20 18 U.S.C. § 1531 (2012).

21 See *Gonzales v. Carhart*, 550 U.S. 124 (2007); *infra* note 146–48 and accompanying text.

22 Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111–148, 124 Stat. 119.

23 In 2010, Obama issued an executive order essentially consistent with the Hyde Amendment. The order was a political concession aimed at persuading Democratic House Representative Bart Stupak to support the PPACA. David Corn, *Obama and the Hyde Amendment*, MOTHER JONES (Mar. 24, 2010, 5:48 PM), <http://www.motherjones.com/mojo/2010/03/obama-and-hyde-amendment> [<http://perma.cc/LFD2-ABHQ>]. The Obama Administration has also revised a regulation from the Bush administration permitting workers in health care settings to refuse to provide advice, information, or services on contraception based on moral objections. Regulation for the Enforcement of Federal Health Care Provider Conscience Protection Laws, 76 Fed. Reg. 9968, 9969 (Feb. 23, 2011) (amending 45 C.F.R. Part 88). Among the conditions of the PPACA are new healthcare provider conscience protections governing the health insurance exchanges. Exec. Order No. 13535, Ensuring Enforcement and Implementation of Abortion Restrictions in the ACA (Mar. 24, 2010).

24 Salganicoff et al., *supra* note 17.

may choose to fund abortions, at least one plan within a state Marketplace must be limited in its coverage only to those types of abortions funded by federal law.²⁵ State Medicaid is likewise constrained by the Hyde Amendment; under that law, Medicaid may not cover abortions beyond the cases of life endangerment, rape, or incest.²⁶ If providers do cover procedures in situations beyond those permitted by federal law, these procedures must be paid from a separate funding pool segregated from federal funds.²⁷

Progress of federal abortion legislation remains stalled. First, the PPACA leaves state abortion regulations untouched. States may continue to pass laws that completely prohibit insurance coverage for any abortions by plans sold in their state Marketplace, even for pregnancies that result from rape or incest, or threaten a woman's life.²⁸ Moreover, legislation directly concerning the right to choose an abortion has stalled. Senate Democrats recently blocked a bill that would have banned most abortions after twenty weeks of pregnancy.²⁹ The Hyde Amendment Codification Act, which aims to make the Hyde Amendment permanent law instead of a yearly rider, was referred to the Committee on Health, Education, Labor, and Pensions in January and has not since emerged.³⁰ Meanwhile, the same Congress is also considering S. 1696, or the Women's Health Protection Act, which aims to prohibit state regulations passed under the pretext of protecting women's health that suppress abortion provision.³¹ The Act was reintroduced in Congress in 2015 and has also not yet emerged from the Subcommittee on Health.³² Most recently, the House of Representatives

25 *Id.*

26 *Id.*

27 *Id.*

28 *Id.*

29 See Pain Capable Unborn Child Protection Act, H.R. 36, 114th Cong. (2015–16), <https://www.congress.gov/bill/114th-congress/house-bill/36> [<http://perma.cc/4L88-JE43>]; Ted Barrett, *Senate Dems Block GOP Abortion Bill*, CNN (Sept. 22, 2015, 11:54 AM), <http://www.cnn.com/2015/09/22/politics/congress-abortion-planned-parenthood> [<http://perma.cc/QVF5-RVBW>].

30 Hyde Amendment Codification Act, *supra* note 15; S. 219, 114th Congress (2014), <https://www.congress.gov/bill/114th-congress/senate-bill/219> [<http://perma.cc/7BA4-H9KY>].

31 S. 217, 114th Congress (2014), <https://www.congress.gov/114/bills/s217/BILLS-114s217is.pdf> [<http://perma.cc/9CMZ-LGED>]. See also H.R. 448, 114th Congress (2015), CONGRESS.GOV, <https://www.congress.gov/bill/114th-congress/house-bill/448> [<http://perma.cc/974T-6KCU>].

32 See H.R. 448, *supra* note 31; Emily Crockett, *Democrats Reintroduce Legislation to Protect Abortion Access*, RH REALITY CHECK (Jan. 21, 2015, 2:55 PM), <http://rhrealitycheck.org/article/2015/01/21/democrats-reintroduce-legislation-protect-abortion-access> [<http://perma.cc/TB6D-FKYV>].

has passed the Born-Alive Abortion Survivors Protection Act,³³ which requires health care practitioners present when a fetus is “born alive” following an abortion to exercise the same degree of care necessary to preserve the life of a fetus born at the same gestational age.³⁴

II. State Regulations of Abortions

Although abortion services expanded significantly after *Roe*,³⁵ state-level restrictions have also increased—especially recently—under the impetus of pro-life lawmakers and advocates.³⁶ Two years before *Roe*, Americans United for Life (AUL) was established to spread pro-life policies, aiming to overturn *Roe* through federal legislation.³⁷ AUL also claims credit for pioneering the state-based model legislative strategy³⁸ that has spread largely identical abortion regulations throughout the States and is likewise espoused by the American Legislative Exchange Council (ALEC). Established the same year that *Roe* was decided, ALEC is known for uniting conservative legislators, policy analysts, and representatives from corporations to create model state legislation embodying conservative policies.³⁹ Together with other conservative lobbying groups such as National Right to Life

33 H.R. 3504, 114th Cong. (2015), <https://www.congress.gov/bill/114th-congress/house-bill/3504> [<http://perma.cc/FZ3B-R3Z5>].

34 Born-Alive Abortion Survivors Protection Act, S. 2066, 114th Cong. (2015), http://www.sasse.senate.gov/public/_cache/files/a3cab92b-d02e-4f8e-8221-65976d359bec/born-alive-abortion-survivors-protection-act.pdf [<http://perma.cc/FB99-HJ65>]. The bill is currently on calendar to be considered by the Senate.

35 Willard Cates, Jr., David A. Grimes & Kenneth F. Schulz, *The Public Health Impact of Legal Abortion: 30 Years Later*, 35 PERSP. ON SEXUAL & REPROD. HEALTH 25, 25 (2003), <https://www.guttmacher.org/pubs/journals/3502503.pdf> [<http://perma.cc/B9RV-HWKT>].

36 *See More State Abortion Restrictions Were Enacted in 2011–2013 Than in the Entire Previous Decade*, GUTTMACHER INST. (Jan. 2, 2014), <https://guttmacher.org/media/inthenews/2014/01/02/index.html> [<http://perma.cc/53C6-CHS3>] [hereinafter *More State Abortion Restrictions*].

37 *About*, AM. UNITED FOR LIFE, <http://www.aul.org/about-aul> [<http://perma.cc/B5AA-QD5Z>] (last visited Mar. 7, 2015).

38 *Charmaine Yoest*, AM. UNITED FOR LIFE, <http://www.aul.org/about-aul/charmaine-yoest> [<http://perma.cc/6TF6-727T>] (last visited Mar. 7, 2015).

39 Alan Greenblatt, *ALEC Enjoys a New Wave of Influence and Criticism*, GOVERNING (Dec. 2011), <http://www.governing.com/topics/politics/ALEC-enjoys-new-wave-influence-criticism.html> [<http://perma.cc/MU5C-NRV9>]. ALEC’s goals include bolstering charter schools, union-busting right to work laws, and climate change denial. *See* Natasha Lennard, *ALEC Makes Public Hundreds of “Model” Bills*, SALON (Mar. 15, 2013 5:25 PM), http://www.salon.com/2013/03/15/alec_makes_public_hundreds_of_model_bills [<http://perma.cc/W8Q3-RQEW>].

(NRTL),⁴⁰ these organizations create and promote pro-life model legislation implemented throughout the states.

In the years following *Roe*, lower federal courts have invalidated many abortion regulations. State legislators responded in turn by limiting public funding for abortions or regulating the primary conduct of women with measures such as mandatory counseling periods.⁴¹ In the 1990s, AUL pivoted to a strategy of incrementally increasing state-imposed restrictions on a woman's right to choose.⁴² Concurrently, state focus on regulating clinics and other elective abortion providers (rather than the woman herself) reemerged in the 1990s and has accelerated since.⁴³

A. State Measures

Due to deadlock at the federal level, the real arena of the abortion access struggle is state-by-state. In the last two decades, state statutes regulating abortion have become more artfully drafted under the influence of multi-pronged pro-life legislative and regulatory campaigns. In 2005, the AUL began annually releasing *Defending Life, a State-By-State Legal Guide to Abortion, Bioethics, and the End of Life*.⁴⁴ Self-styled as “the playbook” of model legislation” in 2005, *Defending Life* aggregates more than fifty pieces of model legislation, expert analysis, and report cards into a handbook for legislators. Other than publishing the model legislation⁴⁵ handbooks, pro-life groups have also sponsored state ballot measures in order to create popular support for increased abortion regulations.⁴⁶

40 NAT'L RIGHT TO LIFE, <http://www.nrlc.org> [<http://perma.cc/Z63G-ZHNZ>] (last visited Nov. 22, 2015). Twelve states have passed laws based on NRTL model legislation. See *Pain Capable Unborn Child Protection Act*, NAT'L RIGHT TO LIFE (Aug. 5, 2015), <http://www.nrlc.org/uploads/stateleg/PCUCAfactsheet.pdf> [<http://perma.cc/8GB7-2NEW>].

41 Gold & Nash, *supra* note 3.

42 Kate Sheppard, *Wham, Bam, Sonogram! Meet the Ladies Setting the New Pro-Life Agenda*, MOTHER JONES (Sept./Oct. 2012), <http://www.motherjones.com/politics/2012/08/americans-united-for-life-anti-abortion-transvaginal-ultrasound> [<http://perma.cc/4JS8-WBSQ>].

43 See *More State Abortion Restrictions*, *supra* note 36.

44 *Defending Life 2015: 10th Anniversary Edition*, AM. UNITED FOR LIFE, <http://www.aul.org/defending-life-2015> [<http://perma.cc/XT7R-Y3BT>] (last visited Mar. 7, 2015).

45 For a model admitting-privileges act, see *Abortion Providers' Admitting Privileges Act*, AM. UNITED FOR LIFE, http://www.aul.org/downloads/2015-Legislative-Guides/Abortion/Abortion_Providers_Admitting_Privileges_Act_-_2015_LG.pdf [<http://perma.cc/5EGX-FBBE>].

46 Nicholas Riccardi, *Abortion Foes' Strategy Advances*, L.A. TIMES (Nov. 23, 2007), <http://www.latimes.com>.

Tennessee, a state in which abortion regulations must satisfy strict scrutiny under the higher protections provided under the state constitution,⁴⁷ recently ratified a state constitutional amendment that gives Tennessee legislators a mandate to create new abortion regulations.⁴⁸ The battle spills into county politics as well. In St. Joseph County, Indiana, a proposed bill required that the name of the doctor providing admitting privileges be filed with the county health department and made publicly available.⁴⁹

Since 2011, states have enacted more than two hundred abortion regulations.⁵⁰ These regulations include limitations on insurance coverage of abortion, bans on abortions at and after twenty weeks, limitations on medical abortion, and bans on abortions if the provider knows that the woman is obtaining the abortion for sex-selection purposes.⁵¹ Other laws incidentally reduced access to abortion. These laws mandate parental involvement, waiting periods, counseling, and ultrasounds for pregnant women.⁵² Currently, twenty-four states have enacted laws or policies that regulate abortion providers, limit medication abortion

com/news/la-na-egg23nov23-story.html#page=1 [http://perma.cc/P3VU-ATUB].

47 Op. Att’y. Gen. No. 05-071, May 3, 2005, 2005 UL 1182346 (clarifying the strict scrutiny standard governing privacy rights imposed by *Planned Parenthood of Middle Tenn. v. Sundquist*, 38 S.W.3d 1 (Tenn. 2000)).

48 The text of the Amendment reads:

Nothing in this Constitution secures or protects a right to abortion or requires the funding of an abortion. The people retain the right through their elected state representatives and state senators to enact, amend, or repeal statutes regarding abortion, including, but not limited to, circumstances of pregnancy resulting from rape or incest or when necessary to save the life of the mother.

How Will Amendment 1 Read on the Ballot?, YES ON 1, http://www.yeson1tn.org/amendment_text [http://perma.cc/VD2U-38DK] (last visited Mar. 8, 2015). See also Anita Wadhvani, *Tennessee Amendment 1 Abortion Measure Passes*, TENNESSEAN, Nov. 6, 2014, <http://www.tennessean.com/story/news/politics/2014/11/04/amendment-takes-early-lead/18493787/> [http://perma.cc/D5ZJ-NTNP].

49 Amanda Gray, *County Councilman Changes Admitting Privileges Bill – Again*, S. BEND TRIB. (Mar. 4, 2015, 5:17 AM), http://www.southbendtribune.com/news/local/county-councilman-changes-admitting-privileges-bill---again/article_e102baa1-6326-5fd9-b781-5885ba185851.html [http://perma.cc/5TSP-H89R].

50 *More State Abortion Restrictions*, *supra* note 36.

51 *Id.* See also NAT’L WOMEN’S LAW CTR., 2014 STATE LEVEL ABORTION RESTRICTIONS: AN EXTREME OVERREACH INTO WOMEN’S REPRODUCTIVE HEALTH CARE (2015), http://www.nwlc.org/sites/default/files/pdfs/2014_state_abortion_legislation_factsheet_1.22.15v2.pdf [http://perma.cc/2M7A-K2LW].

52 2014 STATE LEVEL ABORTION RESTRICTIONS, *supra* note 51.

provision, ban private insurance coverage of abortion, and ban abortions after twenty weeks of pregnancy.⁵³ States enacted ninety-three measures from 2011 through 2013, compared with twenty-two in total from 2001 through 2010.⁵⁴ The number of states considered hostile to abortion rights more than doubled from thirteen in the year 2000 to twenty-seven in the year 2013.⁵⁵

Fifty-six percent of abortion restrictions enacted in 2013 looked to limit women's access to abortion.⁵⁶ In 2014, four states passed targeted regulations of abortion providers—Louisiana and Oklahoma passed laws requiring abortion providers to obtain admitting privileges, while Arizona and Indiana passed laws to allow unannounced inspections of abortion facilities.⁵⁷ The escalating passage of these laws is cause for alarm for reproductive rights advocates, women desiring abortions, and abortion providers.

B. State Regulations of Abortion Providers

Some state restrictions are instituted in the form of TRAP laws, which regulate the medical services component of the abortion process. Notwithstanding the conservative-values-based condemnation that underlies their passage, TRAP laws resemble laws regulating medical procedures⁵⁸ instead of seeking to influence the pregnant woman's decision directly. This characteristic makes TRAP laws and their application to individual physicians and clinics open to legal challenge through advocacy as well as litigation, as evaluation of each case must involve some consultation of the medical literature and evaluation of the proper relationship between scientific fact and morality legislation.

Three general types of laws regulating abortion providers exist: health facility licensing schemes, ambulatory surgical center requirements, and hospitalization requirements.⁵⁹

53 *Id.* See also STATE POLICIES IN BRIEF, *supra* note 4; *More State Abortion Restrictions*, *supra* note 36.

54 Heather D. Boonstra & Elizabeth Nash, *A Surge of State Abortion Restrictions Puts Providers—and the Women They Serve—in the Crosshairs*, 17 GUTTMACHER POL'Y REV. 9, 10 (2014).

55 *Id.* at 10, 11.

56 *More State Abortion Restrictions*, *supra* note 36.

57 2014 STATE LAW ABORTION RESTRICTIONS, *supra* note 51.

58 NAT'L ABORTION FED'N, THE TRAP: TARGETED REGULATION OF ABORTION PROVIDERS 1, 1 (2007), http://prochoice.org/wp-content/uploads/trap_laws.pdf [<http://perma.cc/LBW6-KJRH>].

59 *Targeted Regulation of Abortion Providers (TRAP): Avoiding the TRAP*, CTR. FOR REPROD. RIGHTS (Nov. 1, 2007), <http://www.reproductiverights.org/node/611> [<http://perma.cc/GA47-ECCG>] [hereinafter *Avoiding the*

Each impose requirements beyond what is medically necessary and frequently beyond what is practically or financially feasible for physicians and clinics.⁶⁰ Health facility licensing schemes require only abortion facilities—not similar outpatient procedure facilities—to become state-licensed and comply with a range of regulations. These regulations, that often govern construction, staffing, and other procedures, were designed for ambulatory surgical centers (ASCs), even though these centers provide more invasive and risky procedures than abortion.⁶¹ Ambulatory surgical center requirements mandate that abortion providers not only meet the standards crafted for ASCs but also be licensed as ASCs.⁶² Hospitalization requirements demand that patients be hospitalized for abortions after the fetus has reached a certain gestational age.⁶³

C. Admitting-Privileges Laws and the Privileging Process

Admitting-privileges laws are one of the most common health facility licensing-scheme laws. Currently, sixteen states require or will require abortion facilities or their clinicians to have connections to a local hospital.⁶⁴ Thirteen states have required that doctors who perform abortions have an affiliation with a local hospital: five require providers to possess admitting privileges,⁶⁵ while eight states require either admitting privileges or an alternative arrangement, such as an inter-physician agreement with another doctor who has admitting

TRAP].

60 *Targeted Regulation of Abortion Providers (TRAP)*, CTR. FOR REPROD. RIGHTS (Aug. 28, 2015), <http://www.reproductiverights.org/project/targeted-regulation-of-abortion-providers-trap> [http://perma.cc/Y6AN-CFDN]. See also *infra* notes 96–99, 118–124, and accompanying text.

61 Gold & Nash, *supra* note 3. Several of these laws are extremely detailed, specifying building requirements such as hallway widths or the sizes of procedural rooms, specifications unnecessary to accommodating a gurney used to transport a patient in case of an emergency. ASCs provide same-day surgical care as an alternative to hospital-based outpatient procedures—including pain management surgery, urology, orthopedics, plastic surgery, gastrointestinal surgery, and ophthalmology services. *What is an ASC?*, ASC ASS'N, <http://www.ascassociation.org/AdvancingSurgicalCare/whatisanasc> [http://perma.cc/R5QT-GVLH] (last visited Mar. 8, 2015).

62 *Avoiding the TRAP*, *supra* note 59.

63 *Id.*

64 STATE POLICIES IN BRIEF, *supra* note 4 (adding states with clinician requirements to states requiring transfer arrangements with hospitals).

65 The five states are Missouri, North Dakota, Tennessee, Texas, and Utah. Alabama, Kansas, Louisiana, Mississippi, Oklahoma, and Wisconsin have hospital-privileges requirements enjoined pending a final decision in the courts. *Id.*

privileges.⁶⁶ One state requires that the clinician be either a board-certified obstetrician-gynecologist or eligible for certification.⁶⁷

These requirements ask physicians to undergo the credentialing and privileging process typically used in hospitals to grant or deny admitting or staff privileges for independent physicians.⁶⁸ The specific process to obtain admitting privileges differs from hospital to hospital and may be subject to different state guidelines. A grant of privileges creates an association between that hospital and the admitted physician such that the physician can, depending on the privileges granted, admit her patients or use the surgical facilities.⁶⁹ Hospitals are accordingly discerning about applicants' competency to treat patients. The process is typically split into two parts: credentialing and privileging.⁷⁰ Credentialing is the process by which a practitioner's qualifications are assessed, while privileging is the process by which a health care organization such as a hospital authorizes a practitioner to provide certain services based on the practitioner's demonstrated competence.⁷¹

As information about the credentialing and privileging process is often individual to hospitals and hard to come by, this Note relies on examples assumed to be representative

66 *Id.*

67 *Id.*

68 *See infra* notes 70–71.

69 Virginia McCollum, *Credentialing and Privileging-Implementing Process*, JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGS. (JCAHO), (Mar. 12, 2012), http://www.jointcommission.org/musingsambulatory_patient_safety/guest_blogger_virginia_mccollum_credentiaing_and_privileging-implementing_a_process/ [<http://perma.cc/4HG2-RWVJ>].

70 *See generally* Policy 21: *Physician Credentialing and Privileging*, AM. COLL. OF MED. QUALITY, <http://acmq.org/policies/policy21.pdf> [<http://perma.cc/9AJT-UUTC>] (last visited Oct. 15, 2015).

71 *See* McCollum, *supra* note 69. The credentialing and privileging processes are based on standards set by national accrediting organizations (including the JCAHO or the Accreditation Association for Ambulatory Health Care Inc. (AAAHC)); JCHAO, *AMBULATORY CARE PROGRAM: THE WHO, WHAT, WHEN, AND WHERE'S OF CREDENTIALING AND PRIVILEGING*, http://www.jointcommission.org/assets/1/6/AHC_who_what_when_and_where_credentiaing_booklet.pdf [<http://perma.cc/S3ZP-8ULS>]; *The Credentialing and Privileging Issue*, AAAHC (May 2013), https://www.aaahc.org/Global/pdfs/Connection/2013%20May%20Connection_Final.pdf [<http://perma.cc/H4PU-LVE9>]. The federal Bureau of Primary Health Care endorses and supports these standards. Hospitals that take part in the Federal Torts Claims Act are required by law to adopt credentialing and privileging processes. *See* Credentialing and Privileging of Health Center Practitioners, Memorandum from Marilyn Hughes Gaston, M.D., Dir., Bureau of Primary Health Care, to All Bureau of Primary Health Care Programs (July 17, 2001), <http://bphc.hrsa.gov/policiesregulations/policies/pdfs/pin200116.pdf> [<http://perma.cc/EC56-LHJE>].

of a typical process. The processes will differ at each hospital depending on the set of industry standards followed and the operant legal regime. At Houston Methodist Hospital, the credentialing process occurs in three stages.⁷² The doctor must initiate the process by submitting documentation of their qualifications, including education, training, board certification, valid licensure, and explanation of any malpractice claim history.⁷³ First, the hospital verifies that the information provided is true.⁷⁴ Second, the hospital committee reviews the information gathered by the applicant.⁷⁵ Finally, the hospital committee assesses whether the applicant qualifies for the specific medical staff position for which she has applied.⁷⁶ While some of the process is standardized by the federal Center for Medicare and Medicaid Services,⁷⁷ a large amount of discretion is committed to the hospital.⁷⁸ After credentialing, the hospital makes a decision about whether to grant privileges and what privileges to grant.⁷⁹ In total, the processing time can range from weeks to months.⁸⁰

Typically, the medical staff (comprised mostly of other physicians) makes a decision whether to grant or deny the privileges, although the final decision officially issues from the hospital's board of directors.⁸¹ Generally, practicing physicians are often organized into self-governing medical staffs, which form medical peer review panels that decide

72 Veronica Zaragovia, *What It Takes For Texas Abortion Doctors To Get Admitting Privileges*, KUT.ORG (Feb. 19, 2014), <http://kut.org/post/what-it-takes-texas-abortion-doctors-get-admitting-privileges> [<http://perma.cc/Y4D4-8385>].

73 For a sample list of required documentation, see *Medical/Dental Staff Application Check List*, KALEIDA HEALTH, <https://www.kaleidahealth.org/providers/support/KaleidaHealth-MD-Application.pdf> [<http://perma.cc/677C-GADW>].

74 Zaragovia, *supra* note 72.

75 *Id.*

76 *Id.*

77 *Id.*

78 See *Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786, 791–93 (7th Cir. 2013).

79 *Frequently Asked Questions about Credentialing and Privileges*, KALEIDA HEALTH, http://www.kaleidahealth.org/providers/application_FAQs.asp [<http://perma.cc/SJ2B-BB53>] (last visited Mar. 9, 2015).

80 See *Medical/Dental Staff Application Check List*, *supra* note 73.

81 Sharon A. Christie, Note, *Denial of Hospital Admitting Privileges for Non-Physician Providers—A Per Se Antitrust Violation?*, 60 NOTRE DAME L. REV. 724, 730 (1985) (noting that the decentralized decision-making structure of the privileges increases the risk of group boycott, or a concerted refusal to deal or grant privileges to an individual).

whether a doctor will be granted staff privileges, or whether his privileges should be revoked for cause.⁸² Depending on the state, the record of committee decision-making may be confidential and protected by state law from discovery in civil suit.⁸³

The issue of transparency surrounding the hospital's decision-making is compounded by the larger social context. Hospitals are large facilities: some are religious entities,⁸⁴ others are reliant on religious donors, and still others are publicly supported institutions subject to local social and government pressures.⁸⁵ They are more susceptible than women's clinics to being influenced by strong outrage about the very provision of abortions.⁸⁶ When hospitals are associated with universities, for example, local pro-life organizations have pressured the hospitals to revoke their transfer agreements with local abortion providers on the theory that the existence of the transfer agreement is tantamount to taxpayer funding of abortion.⁸⁷ Other university hospitals have demurred from providing admitting privileges to physicians that perform abortions, wary of associating with "what [the administrator] considered to be a politically contentious organization and procedure"⁸⁸

After receiving admitting privileges, the physician must maintain them. Maintenance requirements can be clerical in nature—such as maintaining the currency of expirable documents such as medical licenses, malpractice insurance, and board certifications.⁸⁹

82 Josephine M. Hammack, *The Antitrust Laws and the Medical Peer Review Process*, 9 J. CONTEMP. HEALTH L. & POL'Y 419, 419 (1993).

83 *Id.* at 440–41.

84 See Jessica Mason Pieklo, *Did Wisconsin Anti-Choice Lawmakers Accidentally Force Catholic Hospitals to Grant Admitting Privileges to Abortion Clinics?*, RH REALITY CHECK (Aug. 13, 2013), <http://rhrealitycheck.org/article/2013/08/13/did-wisconsin-anti-choice-lawmakers-accidentally-force-catholic-hospitals-to-grant-admitting-privileges-to-abortion-clinics/> [<http://perma.cc/8394-S4NJ>].

85 See Robin Marty, *Ohio Shows How an 'Admitting Privileges' Requirement Can Become a Backdoor Abortion Ban*, RH REALITY CHECK (Apr. 5, 2013, 11:55 AM), <http://rhrealitycheck.org/article/2013/04/05/ohio-shows-how-an-admitting-privileges-requirement-can-become-a-backdoor-abortion-ban/> [<http://perma.cc/TKG2-WUBE>]; Sandhya Somashekhar, *Admitting-privileges Laws Have Created High Hurdle for Abortion Providers To Clear*, WASH. POST (Aug. 10, 2014), http://www.washingtonpost.com/national/2014/08/10/62554324-1d88-11e4-82f9-2cd6fa8da5c4_story.html [<http://perma.cc/LS8F-CYUF>]; see also *infra* notes 86–88 and accompanying text.

86 Marty, *supra* note 85.

87 *Id.*; Somashekhar, *supra* note 85.

88 *Id.*

89 *Frequently Asked Questions about Credentialing and Privileges*, *supra* note 79.

Others have a financial aspect: hospitals often mandate that physicians bring to the hospital a minimum number of patients per year.⁹⁰ Still another type is a residency requirement commanding the physician to live within the area.⁹¹

Aside from each specific hospital's individual privileging and maintenance requirements, state law imposes further limitations, which vary in their severity. The more lenient have wider qualifying distances and provide the option for a physician to either obtain admitting privileges or have a written transfer agreement with a local hospital. Another iteration requires the physician to have an agreement with another physician with admitting privileges. The most stringent laws dictate a small qualifying distance to the nearest hospital, or require the physician herself to have admitting privileges, or else face a range of civil and criminal penalties.⁹²

D. The Trouble with Admitting-Privileges Laws

Pro-life legislators evoke safety concerns when passing admitting-privileges laws. One common justification for admitting-privileges laws is that they facilitate continuity of care: abortion providers would be able to provide ongoing care in a hospital setting in the case of a complication.⁹³ Another common justification is that they compel an out-of-town abortion provider to develop a connection to the local area—and by extension, their patients.⁹⁴ Lastly, pro-life advocates justify their admitting-privilege requirement as peer evaluation: the process of applying for admitting privileges provides another chance to evaluate a doctor's competency and suitability as a medical services provider.⁹⁵

These justifications, though not facially unreasonable, nonetheless demand that physicians and clinics make extraneous and often medically unnecessary efforts. Surgical abortions are safer than tonsillectomies, while the risks of medical abortions are even

90 Zaragovia, *supra* note 72.

91 Brian Lyman, *Judge Rules AL Abortion Clinic Law Unconstitutional*, MONTGOMERY ADVERTISER (Aug. 4, 2014), <http://www.montgomeryadvertiser.com/story/news/politics/southunionstreet/2014/08/04/federal-judge-rules-abortion-clinic-law-unconstitutional/13569555/> [<http://perma.cc/9Y3G-G9WN>].

92 *See, e.g.*, 25 TEX. ADMIN. CODE §§ 139.32, 139.33, 139.53 (2009).

93 *Planned Parenthood of Wis., Inc. v. Van Hollen*, 94 F. Supp. 3d 949, 973–77 (W.D. Wis. Mar. 20, 2015).

94 Gold & Nash, *supra* note 3.

95 *Van Hollen*, 94 F. Supp. 3d at 977–980.

lower, as they do not require any anesthesia or invasive surgery.⁹⁶ In many states where the few abortion clinics that are available are located in a metropolitan area, a rural resident may likely seek care from a hospital closer to her than the hospital at which the clinic or doctor obtained admitting privileges.⁹⁷ In the case of any complication that would require hospitalization, the hospital is obligated to admit a patient to emergency care whether or not her doctor has admitting privileges.⁹⁸ The patient is frequently treated whether or not she is linked to a physician with admitting privileges.⁹⁹ Thus, continuity of care is often gratuitous.

Secondly, since surgical abortions are specialized outpatient procedures that commonly take very little time and abortion services are so difficult to access in several regions in the United States, sustained doctor-patient relationships or close ties between a physician and the local area are, while laudable, often also impracticable. A doctor's developing a connection to the local region may not correlate with a stronger doctor-patient relationship or increase existing patient protections. Finally, since all states require that a physician who provides medical care to a patient be licensed to practice medicine in that state, the state medical board has already completed a close evaluation of a doctor's competency to practice medicine.¹⁰⁰

Major medical associations also maintain that admitting-privileges requirements are medically unnecessary and detrimental to the practice of physicians providing abortion.¹⁰¹

96 *What Are The Possible Complications?*, AM. WOMEN'S SERVS., <http://www.americanwomensservices.com/faq/complications.php> [<http://perma.cc/QY3M-LAJL>] (last visited Sept. 30, 2015).

97 *See Van Hollen*, 94 F. Supp. 3d at 976 (“[I]t is simply not credible that plaintiffs’ patients would nevertheless insist on transport to a hospital . . . where the physician who performed the original abortion has admitting privileges, . . . in light of the likely distance from the patient’s home, limitations on travel, and challenges to access to healthcare confronted by women living in poverty . . .”).

98 As guaranteed by the Emergency Medical Treatment and Labor Act of 1986 (EMTALA), 42 U.S.C. § 1395dd (2012).

99 *Van Hollen*, 94 F. Supp. 3d at 975.

100 *Report to the House of Delegates*, 2008, AM. BAR ASS’N, HEALTH L. SECTION, http://www.americanbar.org/content/dam/aba/migrated/health/04_government_sub/media/116B_Tele_Final.authcheckdam.pdf [<http://perma.cc/ZX6D-ZQBT>] (last visited Jan. 2, 2015).

101 *See Jenna Jerman et al.*, AM. PUB. HEALTH ASS’N, *Opposition to Requirements for Hospital Admitting Privileges and Transfer Agreements for Abortion Providers*, http://www.apha.org/~media/files/pdf/policy/a1_oppositiontoadmitting.ashx [<http://perma.cc/3QWY-MKDA>] (stating that the 2003 Ten Core Principles requiring physicians performing surgery in office settings to have admitting privileges at a local hospital

The American Medical Association (AMA) takes the stance that many TRAP laws are unnecessary and impede public health objectives. The AMA has filed a number of amicus briefs in recent abortion-related cases. The association came out against Texas's admitting-privileges law, instead supporting the physician's right to practice ethical medicine "without concern that such exercise will run afoul of non-medical, legal restrictions."¹⁰² The American College of Obstetricians and Gynecologists has also stated its opposition to admitting-privileges and other TRAP laws because of their lack of medical necessity.¹⁰³ Even some local health boards have vocally opposed admitting privileges regulations, stating that no "demonstrable, factual statistical data" has shown a need for these measures, and that "there is generally no support from the medical community" for an ordinance that requires admitting privileges and public disclosure of those doctors who have such privileges.¹⁰⁴

Besides the absence of medical necessity, admitting-privileges laws subject doctors to requirements that can be difficult to satisfy. First, residency requirements can exclude physicians from operating. Because many abortion providers operate in several different states, traveling in and out-of-state for a limited number of procedures, such providers frequently cannot meet a residency requirement in multiple stands.¹⁰⁵ Moreover, a hospital-

is a recommendation that may be outdated, as they were never revisited); FLA. ALLIANCE OF PLANNED PARENTHOOD AFFILIATES, INC., MEDICAL EXPERTS OPPOSE ADMITTING PRIVILEGES LAWS, <http://fappa.org/wp-content/uploads/2015/01/Med-Experts-on-Admitting-Privileges-2015-01-16v2.pdf> [<http://perma.cc/5U9P-BG2V>]; *infra* notes 105–107. *But see* Sarah Terzo, *Abortion doctors and Admitting Privileges – Are Clinics Being Treated Unfairly?*, LIVEACTIONNEWS (Nov. 13, 2013), <http://liveactionnews.org/abortion-doctors-and-admitting-privileges-are-clinics-being-treated-unfairly/> [<http://perma.cc/4SBX-3D5V>].

102 *Case Summaries: Abortion, Planned Parenthood of Greater TX Surgical Health Services v. Abbott*, AM. MED. ASS'N, <http://www.ama-assn.org/ama/pub/physician-resources/legal-topics/litigation-center/case-summaries-topic/abortions.page?> [<http://perma.cc/2JRK-NMF8>] (last visited Jan. 4, 2016).

103 *See, e.g.*, Brief of Amici Curiae American College of Obstetricians and Gynecologists and the American Medical Association in Support of Plaintiffs-Appellees and in Support of Affirmance, *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 734 F.3d 406 (5th Cir. 2013) (No. 13-51008), <http://www.acog.org/-/media/News-Releases/20131220Release.pdf> [<http://perma.cc/M4MS-WL5C>].

104 Amanda Gray, *Health Board Opposes Local Admitting Privileges Bill*, S. BEND TRIB. (Mar. 10, 2015, 6:33 AM), http://www.southbendtribune.com/news/health-board-opposes-local-admitting-privileges-bill/article_611ab766-c6af-11e4-a733-5b387c6a9d7a.html [<http://perma.cc/SM86-EM2B>]; Megan Hickey, *St. Joe Co. Abortion Ordinance Fails By 6-3 Vote*, WNDU (Mar. 11, 2015), <http://www.wndu.com/home/headlines/St-Joe-Co-abortion-ordinance-fails-by-6-3-vote--295855241.html> [<http://perma.cc/F97E-77ZK>].

105 *Id.*; Campbell Robinson & Eric Eckholm, *Judge Blocks Abortion Curb in Mississippi*, N.Y. TIMES (July 29, 2014), <http://www.nytimes.com/2014/07/30/us/mississippi-abortion-clinic-federal-court-blocks-closing.html> [<http://perma.cc/R545-SZBE>].

imposed quota of admitted patients per year can be preclusive.¹⁰⁶ Mandating an abortion provider to regularly bring in patients to the hospital places her in a double-bind because, when done correctly, surgical and medical abortions are safe procedures that rarely require hospitalization.¹⁰⁷

Compared with other medical procedures and especially with childbirth, abortion is extremely safe.¹⁰⁸ Only 0.3 percent of abortion patients in the United States experience a complication that requires hospitalization.¹⁰⁹ Major complications occur in first trimester abortions at a rate of only 0.05–0.06 percent, while second-trimester abortions have a 1.3 percent major complication rate.¹¹⁰ The risk of dying from childbirth is approximately fourteen times higher than that of dying from abortion.¹¹¹ Furthermore, nearly all United States abortions take place in nonhospital settings, with zero detriment in patient safety; studies have found no difference in the risk of death between procedures performed in a hospital and those performed in a clinic or a physician's office.¹¹²

Previous academic commentators examining admitting privileges from the antitrust context have argued that the decentralized decision-making structure of the hospital encourages “group boycott” of outsider medical providers, because it may give power to

106 Robinson & Eckholm, *supra* note 106.

107 See Gold & Nash, *supra* note 3. See *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 769 F.3d 330, 344–45 (5th Cir. 2014) (mem.); *Planned Parenthood of Wis., Inc. v. Van Hollen*, 94 F. Supp. 3d 949, 984–85 (W.D. Wis. 2015).

108 Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legally Induced Abortion and Childbirth in the United States*, 119 OBSTETRICS & GYNECOLOGY 215 (2012); Gold & Nash, *supra* note 3. See also Tracy A. Weitz et al., *Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a California Legal Waiver*, 103 AM. J. PUB. HEALTH 454, 457–58 (2013).

109 See Stanley K. Henshaw, *Unintended Pregnancy and Abortion: A Public Health Perspective*, in A CLINICIAN'S GUIDE TO MEDICAL AND SURGICAL ABORTION 11, 22 (Maureen Paul et al. eds., 1999). See also *Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908, 913 (7th Cir. 2015) (citing studies showing that the incidence of complications requiring hospital admissions is one-twentieth of one percent).

110 *Planned Parenthood of Wisconsin, Inc. v. Schimel*, 806 F.3d 908, 920 (7th Cir. 2015).

111 Raymond & Grimes, *supra* note 108, at 215–19. Nonetheless, many states permit home births under the direction of midwives, who need not be licensed physicians. See *State by State*, MIDWIVES ALL. N. AM., <http://mana.org/about-midwives/state-by-state> [<https://perma.cc/DG99-HG6M>] (last visited Feb. 23, 2016).

112 David A. Grimes, et al., *Abortion Facilities and the Risk of Death*, 13 FAM. PLAN. PERSPS. 30, 30–32 (1981).

effectively license a health care provider to her competitors.¹¹³ Group boycott is defined as a concerted refusal to deal with a competitor, by “keep[ing] them from entering the field or . . . driv[ing] existing competitors out of the field.”¹¹⁴ Effects of group boycott include putting the competitor at a competitive disadvantage, reducing the competitor’s revenues, or raising the competitor’s costs.¹¹⁵ The hospital decision-making structure, in conjunction with the state admitting-privileges mandate, thus exacerbates the result of a staff’s concerted refusal to deal with a provider.¹¹⁶

Whether through endogenous factors like religious disapproval or exogenous pressure, hospitals are frequently unwilling to grant or even consider granting admitting privileges even where the abortion provider is capable of meeting their requirements. Doctors have relayed stories of hospitals unwilling to give out applications, under the apparent justification that hospital policy was to only consider doctors recommended by current physicians at that hospital. Furthermore, lack of institutional transparency can be a major problem not just at the initial stages of requesting applications. Hospitals can and do cite “failures to meet other standards,” such as the admitting privileges quota, or that “none of its staff would write letters in support of the doctors,” as the reasons for denial, neglecting to refer to the underlying causes of, for example, the refusal to write letters: political difference, religious disapproval, or avoidance of public outcry.¹¹⁷

Institutional reluctance has caused major repercussions. In the last few years, providers at Mississippi’s sole abortion clinic could not obtain admitting privileges at any of seven area hospitals.¹¹⁸ Within the year after Texas’ admitting-privileges law was passed, around

113 See Christie, *supra* note 81, at 726 n.16. The abortion context admittedly involves non-economic motives and fits uneasily in the typical antitrust framework, as the hospital staff is unlikely to compete to provide abortion services. However, group boycott in the abortion context shares the same underlying purpose as in a typical economic context: to prevent a physician from providing services in association with a hospital.

114 See *id.*

115 Robert Heidt, *Industry Self-Regulation and the Useless Concept ‘Group Boycott,’* 39 VAND. L. REV. 1507, 1509 (1986).

116 Cf. *Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786, 793 (7th Cir. 2013).

117 See, e.g., Ahmed, *infra* note 289.

118 Sherry Colb, *The Fifth Circuit Blocks Mississippi Law From Closing the Last Abortion Clinic*, VERDICT (Aug. 19, 2014), <http://verdict.justia.com/2014/08/19/fifth-circuit-blocks-mississippi-law-closing-last-abortion-clinic> [<http://perma.cc/T4HN-ZCJU>].

half of the state's thirty-six clinics closed.¹¹⁹ One Texas physician who provided abortions had his medical license temporary suspended after he was found to have conducted his business without obtaining admitting privileges at an area hospital.¹²⁰ Three of Alabama's five clinics would have closed absent an injunction granted pending the district court's final decision.¹²¹ In Oklahoma, a doctor who performs about half of the abortions in the state and is one of only three providers in the state could not obtain admitting privileges at any of the sixteen hospitals in qualifying distance of his clinic.¹²² The wrangling required to obtain admitting privileges not only deters physicians from starting clinics, but has also contributed to an economic climate deterring new doctors from entering the reproductive health services market altogether.¹²³

Legislators have deliberately taken advantage of these collateral effects of asking hospitals to grant admitting-privileges.¹²⁴ State legislative efforts to pass hospital admitting-privileges laws show no signs of slowing; further bills have been introduced or enacted in Arizona, Arkansas, Colorado, Florida, Idaho, Indiana, Iowa, Maryland, New Mexico, Ohio, and South Carolina.¹²⁵ The response by reproductive rights advocates has been to apply for injunctions and to challenge these laws on the merits, under the *Casey* undue burden standard.

119 Cameron McWhirter & Arian Campo-Flores, *Federal Court Blocks Mississippi Law Threatening Abortion Clinic*, WALL ST. J. (July 29, 2014), <http://online.wsj.com/articles/federal-court-blocks-mississippi-law-threatening-abortion-clinic-1406670053> [http://perma.cc/JDP4-KRUX].

120 Zaragovia, *supra* note 72.

121 Planned Parenthood Se., Inc. v. Strange, 9 F. Supp. 3d 1272, 1278–79 (M.D. Ala. 2014); Somashekhar, *supra* note 85.

122 Judge Hears Oral Arguments Over Okla. Admitting Privileges Laws, REPRO HEALTH WATCH (Oct. 20, 2014), <http://go.nationalpartnership.org/site/News2?page=NewsArticle&id=45870> [http://perma.cc/MM6Z-95EY].

123 W. Ala. Women's Ctr. v. Williamson, No. 2:15CV497-MHT, 2015 WL 4873125, at *11 (M.D. Ala. Aug. 13, 2015); Planned Parenthood Se., Inc. v. Bentley, 951 F. Supp. 2d 1280, 1283 (M.D. Ala. 2013).

124 Gold & Nash, *supra* note 3 (quoting a member of the Mississippi House of Representatives: "Anybody here in the medical field knows how hard it is to get admitting privileges to a hospital."); *Mississippi lawmaker: Coat hanger abortions might come back. 'But hey . . . '*, MADDOWBLOG (May 14, 2012), <http://www.msnbc.com/rachel-maddow-show/mississippi-lawmaker-coat-hanger-aborti> [http://perma.cc/JZ9C-W3FG].

125 *Monthly State Update: Major Developments In 2015*, GUTTMACHER INST., <http://www.guttmacher.org/statecenter/updates/index.html#HospitalPrivileges> [http://perma.cc/EUS8-ML7Y] (last updated Nov. 1, 2015).

III. Challenges to State Abortion Regulations

A. The Undue Burden Standard and the Right to Choose an Abortion

The undue burden standard revolutionized the *Roe* framework. *Roe v. Wade* created a trimester framework for evaluating the legality of abortion regulations.¹²⁶ Before the end of the first trimester, the decision to choose an abortion must be left to the woman and her attending physician.¹²⁷ The state may only enter the equation to limit the woman's choice at the start of the second trimester, wherein the state may regulate abortion procedure in ways "reasonably related to maternal health."¹²⁸ Subsequent to viability, the state may regulate and even proscribe abortion, except where necessary to preserve the life or health of the mother.¹²⁹

Nearly twenty years later, the Supreme Court supplanted *Roe*'s analysis with a new, looser standard in *Planned Parenthood of Southeastern Pennsylvania v. Casey*.¹³⁰ *Casey* reaffirmed the existence of right to choose an abortion before fetal viability but expanded the constitutional boundaries of government power to regulate this right.¹³¹

Casey forbids any state law that "imposes an undue burden on a woman's ability" to decide to have an abortion.¹³² A regulation is invalid if it has "the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion" of a nonviable fetus.¹³³ However, a state regulation that incidentally increases the difficulty or cost of an abortion is not facially invalid.¹³⁴ This is because the means chosen by the State to protect

126 *Roe v. Wade*, 410 U.S. 113 (1973).

127 *Id.* at 114.

128 *Id.* at 163. According to *Roe*, the reason is because medical fact at that time stated that until the end of the first trimester, mortality in abortion may be less than mortality in normal childbirth.

129 *Id.* at 163–64.

130 *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992); see also John A. Robertson, *Abortion and Technology: Sonograms, Fetal Pain, Viability, and Early Prenatal Diagnosis*, 14 U. PA. J. CONST. L. 327, 329 (2011) (characterizing the undue burden standard as "looser" than the *Roe* trimester framework).

131 505 U.S. at 833–34, 874.

132 *Id.* at 874.

133 *Id.* at 877.

134 *Id.* at 874 ("The fact that a law which serves a valid purpose, one not designed to strike at the right itself,

its interest in unborn life “must be calculated to inform the woman’s free choice, not hinder it.”¹³⁵ Of the several state law provisions at issue in *Casey*, only one was found to impose an undue burden. Pennsylvania law at the time required that a married woman must certify that she has notified her husband of her decision to have an abortion, except in cases of medical emergency.¹³⁶

The Court invalidated the spousal notification requirement as an undue burden using an analytic that courts and scholars sometimes call the “large fraction” test.¹³⁷ The Court examined spousal notification law not for its effect upon the total number of women seeking abortions in Pennsylvania, but those few for whom it would have an actual effect.¹³⁸ Although the group of women so-restricted constituted less than one percent of the women seeking abortions, the effect on these women was severe enough to create an undue burden in the eyes of the Supreme Court.¹³⁹ The Court also examined the other provisions: a one-parent consent requirement and judicial bypass provision,¹⁴⁰ recordkeeping and reporting requirements,¹⁴¹ informed consent requirements,¹⁴² and twenty-four hour waiting period requirements.¹⁴³ It announced that these provisions created no undue burden on the women affected.¹⁴⁴

has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it.”).

135 *Id.* at 877.

136 *See* *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 844 (1992).

137 *Id.* at 895. *See, e.g.*, *Stenberg v. Carhart*, 530 U.S. 914, 1019 (2000) (Thomas, J., dissenting); *Cincinnati Women’s Servs. v. Taft*, 468 F.3d 361, 367 (6th Cir. 2006); Harper Jean Tobin, *Confronting Misinformation on Abortion: Informed Consent, Deference, and Fetal Pain Laws*, 17 COLUM. J. GENDER & L. 111 (2008); Joshua C. Howard, Note, “No Set of Circumstances” v. “Large Fraction of Cases”: Debate Resolved—*Gonzales v. Carhart*, 127 S. Ct. 1610 (2007), 87 NEB. L. REV. 759 (2009).

138 *Casey*, 505 U.S. at 895 (“ . . . § 3209’s real target is narrower even than the class of women seeking abortions identified by the State: it is married women seeking abortions who do not wish to notify their husbands of their intentions and who do not qualify for one of the statutory exceptions to the notice requirement.”).

139 *Id.* at 837–38.

140 *Id.* at 899–900.

141 *Id.* at 900–01.

142 *Id.* at 884–87.

143 *Id.* at 885–97.

144 *Casey*, 505 U.S. at 884–901.

More recently, *Gonzales v. Carhart* applied *Casey* to uphold the constitutionality of the federal Partial-Birth Abortion Ban Act.¹⁴⁵ *Gonzales* concerned a federal statute that prohibited intact dilation and extraction abortions, an uncommon procedure that is performed in the second trimester. This case was remarkable for several reasons. First, the federal statute did not contain an exception for pregnancies that endangered a woman's health. Second, it suggested that banning specific abortion methods could be justified in part by the government's interest in protecting the woman from the emotional consequences of her abortion decision.¹⁴⁶ The Court held that where a state acts on a rational basis, and where it does not impose an undue burden on women, it can regulate abortion by barring certain procedures and substituting others.¹⁴⁷ Many commentators interpreted this decision to signal greater Supreme Court approval toward state-imposed abortion restrictions.¹⁴⁸

Carhart also illustrated the malleability of *Casey*'s undue burden standard. The Court decided that because medical uncertainty existed over whether the Act's prohibition of partial-birth abortions creates significant health risks, a sufficient basis existed for the Court to decide that the Act does not impose an undue burden.¹⁴⁹ This move can be read as

145 *Gonzales v. Carhart*, 550 U.S. 124, 124 (2007).

146 Transcript, *After Gonzales v. Carhart: The Future of Abortion Jurisprudence*, PEW RES. (June 14, 2007), <http://www.pewforum.org/2007/06/14/after-gonzales-v-carhart-the-future-of-abortion-jurisprudence/> [http://perma.cc/NB3R-K76D].

147 *Carhart*, 550 U.S. at 158.

148 See Katia Desrouleaux, *Banning Partial-Birth Abortion at All Costs—Gonzales v. Carhart: Three Decades of Supreme Court Precedent “Down the Drain,”* 35 S.U. L. REV. 543 (2008) (“[*Carhart*] predicts the beginning of a rapid erosion of the right to abortion, irrespective of health and safety considerations. An overturn of *Roe* could very well be the next item on the Supreme Court's agenda.”); Martha K. Plante, “Protecting” Women's Health: How *Gonzales v. Carhart* Endangers Women's Health and Women's Equal Right to Personhood Under the Constitution, 16 AM. U. J. GENDER SOC. POL'Y & L. 387, 395, 399–401 (2008); see also Anthony V. Agudelo, *Gonzales v. Carhart—the Supreme Court's Recent Abortion Decision: What It Means Now and May Mean for the Future*, 9 MASS. BAR ASS'N SECTION REV. (2009), <http://www.massbar.org/publications/section-review/2007/v9-n3/gonzales-v-carhart-%E2%80%93-the-supreme-court%E2%80%99s-recent-abortion-decision-what-it-means-now-and-may-mean-for-the-future> [http://perma.cc/37XC-N8EC].

Furthermore, the Court adopts the opposite view and says that state and federal legislatures have “wide discretion to pass legislation in areas where there is medical and scientific uncertainty.” . . . Now, with a victory in their pockets from the *Gonzales* case, pro-life advocates will likely press state legislators to draft laws that will revive “partial-birth abortion” laws and further narrow women's abortion rights, and *Gonzales* will undoubtedly embolden state legislatures to craft further abortion restrictions.

149 *Carhart*, 550 U.S. at 164.

a way of avoiding the large-fraction test—because the number of women actually affected by a ban on partial-dilation procedures is unknown, there was no basis to conclude that the Act creates an undue burden and the law was presumptively valid. As discussed in the next Section, lower court decisions also demonstrate the difficulty of applying the undue burden standard in a principled and consistent fashion.¹⁵⁰

B. Applying “Undue Burden” to Admitting-Privileges Laws

Following *Casey*, pro-choice advocates have mounted challenges to the deluge of TRAP laws on the undue burden theory.¹⁵¹ A recent search revealed twenty-one federal decisions, interim orders, or motions that specifically address admitting privileges, with the majority published since 2013. While some cases have been mooted, like that of a North Dakota clinic that finally received admitting privileges from a South Dakota hospital within the required distance,¹⁵² the majority of these cases are ongoing, making clarification of the standard a vital and pressing concern.

Courts grapple with applying the undue burden standard in individual cases.¹⁵³ Part of the challenge of using “undue burden” is that success on the merits depends largely on the framing of the “large fraction” for which a burden is assessed, not necessarily on the degree of burden actually imposed on individual woman or her abortion provider. The denominator of that “large fraction” is endlessly malleable. Accordingly, *Casey*’s undue burden inquiry has provided at best inconsistent protection of women’s access to abortion.

150 Linda J. Wharton et al., *Preserving the Core of Roe: Reflections on Planned Parenthood v. Casey*, 18 YALE J.L. & FEMINISM 317, 353 (2006) (finding through empirical study that in a significant number of cases, federal courts have repudiated or misapplied *Casey* protections, manipulating the undue burden standard to undermine *Roe*’s protections and requiring “unattainably high levels of proof of undue burden”). See also Jessica Mason Pieklo, *For Too Many, Accessing Abortion Is Already an ‘Undue Burden,’* RH REALITY CHECK (Mar. 11, 2014), <http://rhrefactcheck.org/article/2014/03/11/many-accessing-abortion-already-undue-burden> [<http://perma.cc/F9F4-E9ZT>].

151 See, e.g., *Planned Parenthood of Greater Tex. Surgical Health Servs v. Abbott*, 734 F.3d 406 (5th Cir. 2013); *Tucson Woman’s Clinic v. Eden*, 379 F.3d 531 (9th Cir. 2004); *Planned Parenthood of Wis., Inc. v. Van Hollen*, 963 F. Supp. 2d 858 (W.D. Wis. 2013); *Planned Parenthood Se., Inc. v. Bentley*, 951 F. Supp. 2d 1280 (M.D. Ala. 2013).

152 See *MKB Mgmt. Corp. v. Burdick*, 954 F. Supp. 2d 900 (D.N.D. 2013); *MKB Management Corp et al. v. Burdick et al.*, CTR. FOR REPROD. RTS. (June 6, 2014), <http://www.reproductiverights.org/case/mkb-management-corp-et-al-v-burdick-et-al> [<http://perma.cc/4XA7-T9UW>].

153 Wharton et al., *supra* note 150. See also Neal Devins, *How Planned Parenthood v. Casey (Pretty Much) Settled the Abortion Wars*, 118 YALE L.J. 1318, 1322, 1329 n.45 (2009) (“*Casey* is a sufficiently malleable standard that it can be applied to either uphold or invalidate nearly any law that a state is likely to pass.”).

Separate cases filed in similar circumstances that involve formally similar statutes are often resolved quite differently based on irregular judicial determinations of what would constitute an “undue burden.”¹⁵⁴

For example, in 2014 the Fifth Circuit differently decided two cases that both involved laws with substantially similar admitting-privileges provisions. The court held that a challenge to a Mississippi admitting-privileges law, which would have had the effect of closing the only clinic in the state, had a substantial likelihood of success on the merits.¹⁵⁵ Yet the same court of appeals had four months earlier rejected a Texas admitting-privileges law challenge, finding it did not create an undue burden.¹⁵⁶ The cogent difference in the later case, according to the Fifth Circuit, was whether the law would effectively shut down the only abortion clinic in the state and pose an undue burden as applied to the women of Mississippi.¹⁵⁷ In Texas, while a burden would likely fall upon residents in a particular sector of twenty-four counties in the Rio Grande Valley, the court found this did not impose a burden on Texas residents generally.¹⁵⁸

An example of the difficulty of “correctly” applying the undue burden test appears in the passionate dissent from the Fifth Circuit’s denial of rehearing en banc in the prior case, involving Texas’s abortion regulations.¹⁵⁹ Judge Dennis argued that the three-judge panel decision in *Planned Parenthood of Greater Texas Surgical Health Services v. Abbott*

154 See *infra* notes 159–63 and accompanying text.

155 Jackson Women’s Health Org. v. Currier, 760 F.3d 448 (5th Cir. 2014).

156 Planned Parenthood of Greater Tex. Health Servs. v. Abbott (Abbott II), 748 F.3d 583, 600 (5th Cir. 2014) (sustaining the admitting privileges requirement of H.B. 2 on the basis that it does not impose an undue burden on the vast majority of Texas women seeking abortions, and the burden that it imposes on women is less than the waiting-period provision upheld in *Casey*).

157 Jackson Women’s Health, 760 F.3d at 457 (holding also that a state may not “lean on its sovereign neighbors to provide protection of its citizens’ federal constitutional rights”); see also *id.* at 461–62 (Garza, J., dissenting). In a subsequent decision, the Fifth Circuit distinguished its previous holding that a state may not offload its constitutional duties to provide protection of access to abortion by focusing on individual choice. The court reasoned that Texas regulations did not pose an undue burden in part because women in El Paso could and did “choose” to travel twelve miles over the border to New Mexico’s abortion facility instead of 550 miles to the nearest Texas facility. *Whole Woman’s Health v. Cole*, 790 F.3d 563, 598 (5th Cir. 2015), *modified*, 790 F.3d 563 (5th Cir. 2015), *cert. granted*, 136 S. Ct. 499 (2015).

158 Abbott II, 748 F.3d at 598.

159 Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott, 734 F.3d 406 (5th Cir. 2013), *rehearing denied en banc*, Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott (Abbott III) 769 F.3d 330 (5th Cir. 2014).

(*Abbott II*) incorrectly employed the *Casey* test by applying “what effectively amounts to a rational-basis test . . . under the guise of applying the undue burden standard.”¹⁶⁰ Moreover, he argued that the court mishandled the “large fraction” test when assessing the effect of the admitting-privileges and medical-abortion provisions “by disregarding the effect of the law in light of the relevant context and circumstances faced by the women for whom the law is relevant (i.e., for whom it actually burdens).”¹⁶¹ Judge Dennis cited the district court’s findings that “approximately one in three women” in Texas seeking an abortion would be precluded from accessing an abortion, and that forty percent of women seeking abortions in Texas are at or below the federal poverty line, and thus are unable to travel the distances necessary to access abortions should the clinics in their area close.¹⁶² By contrast, the majority had held that since more than ninety percent of women seeking an abortion in Texas would be able to find a clinic within one hundred miles of their respective residences, no undue burden was created for a large fraction of the relevant cases.¹⁶³ To restate, Dennis’s denominator was the women in the Rio Grande Valley; the majority’s denominator was Texas women generally.

Application of the *Casey* standard is difficult not only because it requires a highly fact-sensitive inquiry into the effect of an abortion regulation as applied, but also because of the often unacknowledged judgment involved in framing the “large fraction” for whom the burden will be assessed. For a poor, pregnant woman living in Texas’s Rio Grande Valley, the distinction drawn by the three-judge panel of the Fifth Circuit between Mississippi and Texas is nearly meaningless. Even if she were able to come up with the money for the procedure, geography would pose a burden. The drive from the Rio Grande Valley to San Antonio, where the next closest clinic would be should the ambulatory surgical center requirement go into effect, is between 230 and 250 miles.¹⁶⁴ The drive from Corinth, Mississippi, on the border between Mississippi and Tennessee, to Jackson, the locale of the only remaining clinic, is 239 miles. Yet that panel assessed the respective laws based on the entire population of Texas and Mississippi, finding Texas’s admitting-privileges law constitutional but Mississippi’s unconstitutional.

160 *Abbott III*, 769 F.3d at 332.

161 *Id.* at 330, 335.

162 *Id.* at 361.

163 *Planned Parenthood of Greater Tex. Health Servs. v. Abbott*, 748 F.3d 583, 598 (5th Cir. 2014).

164 *Whole Woman’s Health v. Lakey*, 769 F.3d 285, 303 (5th Cir. 2014).

This analytic difficulty presages a circuit split. While some courts of appeal have sustained admitting-privileges requirements,¹⁶⁵ at least one other circuit has indicated that admitting-privileges requirements constitute an undue burden.¹⁶⁶ Under the factors relevant to an undue burden analysis, these decisions hinge largely on the factual context of each state and judicial discretion in framing the “large fraction.” Assuming that the state denies allegations of bad faith or an invalid purpose to burden abortion providers,¹⁶⁷ laws such as admitting-privileges requirements might be better challenged in a way that targets the procedures and lack of safeguards involved in the process of obtaining admitting privileges.

C. An Introduction to Private Delegation Challenges

Admitting-privileges laws take a standard form: shared public and private input in regulatory decision-making. Faced with resource constraints, governments often rely on private entities to achieve regulatory goals. Private participation in government decision-making, implementation, and enforcement is so entrenched that the borders between public and private sectors are often blurred.¹⁶⁸

Distributing regulatory power to private entities creates benefits outside of easing government costs—state and federal governments can take advantage of private expertise and specialization. Federal and state agencies often rely on private parties to set standards, delegating power to a number of self-regulating bodies that set and implement

165 *Greenville Women’s Clinic v. Comm’r, S.C. Dep’t of Health & Env’tl Control*, 317 F.3d 357, 363 (4th Cir. 2002) (finding a South Carolina regulation requiring abortion providers to have admitting privileges at a local hospital to be “so obviously beneficial to patients”); *Women’s Health Ctr. of W. Cnty., Inc. v. Webster*, 871 F.2d 1377, 1381 (8th Cir. 1989) (ruling that a Missouri statute requiring abortion providers to have admitting privileges “furthers important state health objectives”).

166 *See Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908, 922 (7th Cir. 2015) (affirming lower court’s permanent injunction against a Wisconsin admitting-privileges law for imposing an undue burden).

167 Notably, in Mississippi’s case, the State waived any argument that the law would not close the last remaining abortion clinic. *Jackson Women’s Health Org. v. Currier*, 760 F.3d 448 (5th Cir. 2014). *See also* *Jackson Women’s Health Org. v. Currier*, 940 F. Supp. 2d 416, 423 (S.D. Miss. 2013) (“Because of its conclusion as to the effect of the Act, the Court need not consider the thorny question whether public statements from numerous State officials lauding the Act as a ban on abortion in Mississippi are alone sufficient to demonstrate unconstitutional purpose.”).

168 Ralph M. Kramer, *Voluntary Agencies and the Contract Culture: “Dream or Nightmare?”*, 68 SOC. SERV. REV. 33, 35 (1994); Gillian Metzger, *Privatization as Delegation*, 103 COLUM. L. REV. 1367 (2003) [hereinafter Metzger, *Privatization*].

standards.¹⁶⁹ They also rely on private parties to provide services, design policies, and implement regulatory structures.¹⁷⁰ Frequently cited examples include Medicare and Medicaid Managed Care,¹⁷¹ private prisons,¹⁷² military contractors,¹⁷³ and Standard Setting Organizations (SSOs) such as the New York Stock Exchange,¹⁷⁴ among others.

Accountability concerns grow from the increasing allocation of discretionary regulatory powers to private entities.¹⁷⁵ Private entities often do not face the multiple layers of oversight to which public actors are subject.¹⁷⁶ Private parties' motivations also differ, such that ideology, profit, or related factors may dampen private responsiveness to community concerns. Private parties also lack the culture of public-mindedness that public agencies tend to foster.¹⁷⁷

Outside of the clear governance benefits, reliance on industry expertise is often justified by the argument that private parties are best equipped to self-regulate. Yet "self-regulation" is arguably a myth. The actual structure of "self-regulation" resembles either a group in an industry regulating other people in that industry, a group regulating their competitors, or a group regulating another, related group.¹⁷⁸ When private parties regulate, they can control third parties' access to government benefits and resources.¹⁷⁹ Thus, judicial review

169 Jody Freeman, *The Private Role in Public Governance*, 75 N.Y.U. L. REV. 543, 551 (2000).

170 *Id.*

171 Metzger, *Privatization*, *supra* note 168, at 1380.

172 *Id.* at 1380.

173 Paul R. Verkuil, *Public Law Limitations on Privatization of Government Functions*, 84 N.C. L. REV. 397, 441–46 (2006).

174 *Id.* at 433.

175 Freeman, *supra* note 169, at 574.

176 These include intra-agency oversight, public reaction through the use of the political process, and judicial review.

177 See Freeman, *supra* note 169, at 550. Cf. Verkuil, *supra* note 173, at 468 ("When private contractors perform inherent government functions, they jeopardize core values of public law and weaken government's capacity to do the common good.").

178 Alexander Volokh, *The New Private-Regulation Skepticism: Due Process, Non-Delegation, and Antitrust Challenges*, 37 HARV. J.L. & PUB. POL'Y 931, 934 (2014).

179 Metzger, *Privatization*, *supra* note 168, at 1371.

of private-public delegations can allay fears that use of private decision makers would disrupt democratic accountability.

Courts continue to express discomfort with private delegations,¹⁸⁰ fearing that a delegation of a properly governmental power outside of the structures of government can and frequently does lead to arbitrary governance.¹⁸¹ Privatization of regulatory functions, because it involves delegation of power without ensuring the presence of the legally necessary nexus between the government and the private actor to bring the private actor under state action doctrine, often creates constitutional accountability problems.¹⁸² State action doctrine can curb *government* malfeasance; conversely, acts by purely private actors are generally beyond the reach of the Constitution.¹⁸³

With respect to admitting-privileges requirements, absent an effective standard of government review, hospitals may not be accountable to the interests of the privacy rights of individual women. If the hospital's actions are not actionable in civil litigation and the government has not limited the hospital's ability to act capriciously or arbitrarily in deciding to give or withhold effective licenses, the admitting-privilege law, and by extension the state, will have circumvented the Fourteenth Amendment's protections of individual due process rights.

As explained in this Section, current doctrines of American constitutional law require "clear boundaries" to be placed on the exercise of discretion where governmental power has been delegated to a private, non-state actor.¹⁸⁴ Courts have tackled the problem of improper delegation through two doctrines: non-delegation and due process. Frequently these two analyses become muddled. To distinguish the applicable due process doctrine, this Part will briefly describe non-delegation doctrine in both its state and federal forms.

180 *Larkin v. Grendel's Den, Inc.*, 459 U.S. 116 (1982) (standardless delegation to churches of an effective veto on liquor licenses equivalent to traditional government liquor license violates the First Amendment by vesting traditional government authority in churches); *A.L.A. Schechter Poultry Corp. v. United States*, 295 U.S. 495, 537 (1935); *Tex. Boll Weevil Eradication Found., Inc. v. Lewellen*, 952 S.W.2d 454, 469 (Tex. 1997). See also Note, *Vagaries of Vagueness, Rethinking CFAA as A Problem of Private Delegation*, 127 HARV. L. REV. 751, 763 (2013) [hereinafter *Vagaries of Vagueness*].

181 *Vagaries of Vagueness*, *supra* note 180, at 761–62.

182 Metzger, *Privatization*, *supra* note 168, at 1377.

183 See generally Cass R. Sunstein, *Lochner's Legacy*, 87 COLUM. L. REV. 873, 886 (1987).

184 *Planned Parenthood of Wis. Inc. v. Van Hollen*, 23 F. Supp. 3d 956, 962 (W.D. Wis. 2014) (citing *United States v. Goodwin*, 717 F.3d 511, 517 (7th Cir. 2013)).

1. Delegation Doctrine

Courts sometimes resolve claims of improper delegation to private parties under non-delegation doctrine. The conventional version of federal non-delegation doctrine arises from an interpretation of the Vesting Clause in Article I of the United States Constitution that theorizes that all legislative powers belong exclusively to Congress.¹⁸⁵ Non-delegation doctrine forbids Congress from authorizing another branch of government to exercise lawmaking powers because proper lawmaking must pass through the bicameralism and presentment processes.¹⁸⁶ However, broad delegations of legislative authority are constitutional so long as Congress supplies an “intelligible principle” that sets bounds on the person or body authorized.¹⁸⁷

While the typical non-delegation doctrine is a doctrine of public governance rooted in the constitutional principle of separation of powers, some scholars identify a “cousin,”¹⁸⁸ private non-delegation doctrine, which precludes overbroad Congressional grants of power to private parties.¹⁸⁹ In addition to federal non-delegation doctrine, various state courts

185 Thomas W. Merrill, *Rethinking Article I, Section 1: From Non-delegation to Exclusive Delegation*, 104 COLUM. L. REV. 2168 (2004). For the courts’ interpretation, see, e.g., *Whitman v. Am. Trucking Ass’n*, 531 U.S. 457, 472 (2001) (“[The] text of [Article I, section 1] permits no delegation of [legislative] powers.”); *Crain v. First Nat’l Bank of Or., Portland*, 324 F.2d 532, 537 (9th Cir. 1963) (reasoning that, under Article I, section 1, “Congress cannot delegate to private corporations or anyone else the power to enact laws”).

186 Merrill, *supra* note 185, at 2126.

187 *J.W. Hampton, Jr., & Co. v. United States*, 276 U.S. 394, 409 (1928).

188 See, e.g., *Ass’n of Am. R.R.s. v. U.S. Dep’t of Transp.*, 721 F.3d 666, 670 (D.C. Cir. 2013), *vacated and remanded sub nom. Dep’t of Transp. v. Ass’n of Am. R.R.s.*, 135 S. Ct. 1225 (2015) (AAR); Froomkin, *infra* note 213, at 28 n.33.

189 David Horton, *Arbitration as Delegation*, 86 N.Y.U. L. REV. 437, 473–74 (2011). Academic controversy persists over whether the private-public distinction in non-delegation doctrine is meaningful. Some scholars argue that the private-public distinction is unnecessary for federal non-delegation cases, because the significant issue is not the party to whom the legislature has given power, but whether the legislature has given up power without sufficient standards. See, e.g., Harold J. Krent, *The Private Performing the Public: Delimiting Delegations to Private Parties*, 65 U. MIAMI L. REV. 507, 511 (2011); Volokh, *supra* note, 178 at 958, 960. Others argue that non-delegation doctrine is “more muscular” as applied to private parties, because the exercise of private power entails fewer safeguards. Horton, *supra*, at 472–73. The need for more protections against abuses of power and undemocratic governance makes the “private” non-delegation doctrine distinction useful, because the stakes are higher. *Id.* at 472–73. For one account of private delegation, see Horton’s argument that the private non-delegation doctrine does not rely on the “intelligible principle” test, but on a three-factor inquiry examining whether the delegation (1) authorizes private actors to make law in a non-neutral, nontransparent way, (2) provides adequate representation to affected parties through the private lawmaking process, and

have created their own private delegation analyses.

Some of these state private non-delegation analyses are stricter than the “intelligible principle” federal standard.¹⁹⁰ Many of these states are those in which reproductive rights litigation is underway, including Texas, Florida, Arizona, and Oklahoma.¹⁹¹ Some of these states clearly ground their doctrines in separation of powers concerns; others specifically impose limits on delegations to private parties.¹⁹²

Even the Supreme Court, however, has struck down delegations with reference to the private-public nature of the delegation.¹⁹³ In *Carter v. Carter Coal*, the Court famously held the Bituminous Coal Conservation Act had made an arbitrary delegation that violated both Article I of the Constitution and the Due Process Clause.¹⁹⁴ Congress had empowered a majority of miners and large coal producers in the coal districts to prescribe hours, wages, and prices within their respective districts. Any who did not comply were subject to an excise tax. The Court invalidated the law as being “legislative delegation in its most obnoxious form.”¹⁹⁵ *Carter Coal* has been taken as the basis for private non-delegation doctrine, though some controversy over the constitutional basis of this decision persists.¹⁹⁶

(3) whether the state retains control over the private delegate. Horton’s test, however, belies the fact that these factors sound in due process, not separation of powers.

190 See, e.g., *Tex. Boll Weevil Eradication Found., Inc. v. Lewellen*, 952 S.W.2d 454 (Tex. 1997). For an exposition of current state non-delegation doctrines, see Volokh, *supra* note 178, at 961–70.

191 Volokh, *supra* note 178, at 961–70.

192 These states are Iowa, Minnesota, Pennsylvania, and South Carolina. Volokh, *supra* note 178, at 961–70.

193 See also *A.L.A. Schechter Poultry Corp. v. United States*, 295 U.S. 495, 537 (1935) (“Could trade or industrial associations or groups be constituted legislative bodies for [enacting laws for the rehabilitation and expansion of their trade and industries] because such associations or groups are familiar with the problems of their enterprises? . . . The answer is obvious. Such a delegation of legislative power is unknown to our law and is utterly inconsistent with the constitutional prerogatives and duties of Congress.”); Volokh, *supra* note 178, at 958 n.137.

194 *Carter v. Carter Coal Co.* 298 U.S. 238, 311 (1936). In response to *Carter Coal*, Louis Jaffe argues that private delegation analysis really asks whether the delegation is reasonable within the limits of due process; he accurately predicted that due process would become the face of delegation doctrine that survives federally. See Louis L. Jaffe, *Lawmaking by Private Groups*, 51 HARV. L. REV. 201, 248 (1937). Accord Volokh, *supra* note 178, at 979.

195 *Carter*, 298 U.S. at 311.

196 Discussed *infra* I.B.

Subsequent private delegation challenges floundered in *Currin v. Wallace*¹⁹⁷ and *Sunshine Anthracite Coal Co. v. Adkins*,¹⁹⁸ where the Court found no impermissible delegation of legislative power to private actors. In *Currin*, the Court sustained a regulatory scheme where the Secretary of Agriculture was authorized to promulgate binding uniform tobacco standards if two-thirds of the growers in an area voted in favor of such regulation.¹⁹⁹ Here the substantive content of the regulations was determined by public officials; private individuals held a trigger, like an on-off switch, to implement the regulations.²⁰⁰ In *Adkins*, the constitutionality of a second Bituminous Coal Act was upheld where local coal producers may set rules governing the sale of coal, subject to the approval of a government agency. The key to a delegation's viability is whether the Government retains control over privately created regulations.

2. The Relevance of Delegation Doctrine

Commentators and even courts have sometimes labeled a due-process-based analysis by the name of non-delegation doctrine.²⁰¹ For the purposes of due process analysis, whether non-delegation doctrine is violated depends not on the private or public nature of the delegatee, but on the extent and nature of the delegation.²⁰² Federal law considers the constitutionality of TRAP laws only by the rubric of whether they comply with the Due Process Clause. The federal non-delegation doctrine, even applying to private parties, does not extend to state legislation, unlike due process, which binds the states under the Fourteenth Amendment. Yet non-delegation is important to explain, because it persists both as a canon of interpretation, and possibly in its state law formulations as a dark horse approach to attacking admitting-privileges laws.

Received wisdom declares that federal non-delegation doctrine is dead.²⁰³ The Supreme Court has deployed it only twice to strike down a federal statute, both times

197 *Currin v. Wallace*, 306 U.S. 1 (1939).

198 *Sunshine Anthracite Coal Co. v. Adkins*, 310 U.S. 381, 387–88 (1940).

199 *Currin*, 306 U.S. at 19.

200 See Metzger, *Privatization*, *supra* note 168, at 1399–1400; Volokh, *supra* note 178, at 959.

201 Volokh, *supra* note 178, at 933.

202 Metzger, *Privatization*, *supra* note 168, at 1400.

203 Freeman, *supra* note 169, at 591 (“[T]he nondelegation doctrine shows no credible signs of coming back to life.”).

during the New Deal era.²⁰⁴ Any doubt of non-delegation doctrine's irrelevance in the modern administrative state was purportedly dispelled with *Whitman v. American Trucking Associations*,²⁰⁵ in which the Supreme Court rejected an improper delegation argument, reiterating that properly delegated powers under the Clean Air Act requires only that an intelligible principle exists, and the scope of discretion provided to the Environmental Protection Agency remained within the outer limits of non-delegation precedents.²⁰⁶ The Court has had other opportunities to resurrect non-delegation as grounds of decision, but demurred.²⁰⁷

Yet non-delegation doctrine resurfaces at the Supreme Court level in ways other than as grounds of decision. Justice Blackmun has noted that non-delegation doctrine lives on as a principle of statutory interpretation akin to constitutional avoidance.²⁰⁸ Moreover, the lower courts still cite the doctrine today. Although the U.S. Supreme Court has not invalidated a law on non-delegation grounds—let alone private non-delegation grounds—

204 *Panama Refining Co. v. Ryan*, 293 U.S. 388, 430 (1935); *A.L.A. Schechter Poultry Corp. v. United States*, 295 U.S. 495, 542 (1935).

205 *Whitman v. Am. Trucking Ass'n*, 531 U.S. 457 (2001). *See also* *Mistretta v. United States*, 488 U.S. 361, 372 (1989) (“[I]n our increasingly complex society, replete with ever changing and more technical problems, Congress simply cannot do its job absent an ability to delegate power under broad general directives. Accordingly, this Court has deemed it ‘constitutionally sufficient’ if Congress clearly delineates the general policy, the public agency which is to apply it, and the boundaries of this delegated authority.”). The Court declined to consider non-delegation doctrine as its grounds of decision in *Clinton v. City of New York*. *Clinton v. City of N.Y.*, 524 U.S. 417 (1998).

206 *Whitman*, 531 U.S. at 472.

207 *See, e.g., Clinton*, 524 U.S. 417; *Dep’t of Transp. v. Ass’n of Am. R.Rs.*, 135 S. Ct. 1225 (2015). In *AAR*, the D.C. Circuit decision below, *Ass’n of Am. R.Rs. v. Dep’t of Transp.*, 721 F.3d 666 (D.C. Cir. 2013), invalidated a regulatory scheme under which Amtrak, a private corporation heavily subsidized by the Government and chartered by federal law, shared joint authority with the Federal Railroad Administration to determine metrics and standards for rail companies. The Supreme Court reversed the case on the grounds that Amtrak was in fact a government entity for the purposes of the federal law, mooted the private delegation question, in March 2015. *See AAR*, 135 S. Ct. at 1225.

208 *Mistretta v. United States*, 488 U.S. 361, 374 n.7 (1989) (“In recent years, our application of the non-delegation doctrine principally has been limited to the interpretation of statutory texts, and, more particularly, to giving narrow constructions to statutory delegations that otherwise might be thought unconstitutional.”). *See also* Cass R. Sunstein, *Non-delegation Canons*, 67 U. CHI. L. REV. 315–16 (2000) (non-delegation lives on in canons of construction, susceptible to principled judicial application); John F. Manning, *The Non-delegation Doctrine as a Canon of Avoidance*, 2000 SUP. CT. REV. 223.

since *Carter Coal*, lower federal courts and state courts continue to deploy private non-delegation doctrine in various forms.²⁰⁹

3. Due Process Principles and Private Decision Makers

Federal court challenges to state law-based delegations typically sound in due process. Because the Fourteenth Amendment binds the states, due process protections apply where a private actor has “taken the decisive step to cause the harm” to the injured party, and a sufficient nexus exists between the decision and the state, such that the action can fairly be characterized as the act of the state itself.²¹⁰ Hints of a possible due process problem arise where there is both delegation of power and pecuniary interest.²¹¹

Due process analysis and non-delegation doctrines differ at the point where the unconstitutional action is identified. Non-delegation doctrine points to a law’s unconstrained delegation of power, while due process accounts for the lack of notice, an impartial adjudicator, and an opportunity to be heard—all of which can be instituted with appropriate legislative constraints. The distinction makes a difference when we examine state laws and regulations: the due process analysis binds state laws and regulations, while a federal separation of powers analysis cannot, without incorporation into state law, independently bind states.²¹²

To invalidate state laws, the lower courts consider whether a delegation deprives parties of a protected property interest.²¹³ Commentators surveying these decisions have identified various factors called private delegation by lower courts, including whether affected parties are adequately represented; whether the state retains control over the authorized private decision maker, and whether the private actors are authorized to make law in a non-

209 See, e.g., *Gen. Elec. Co. v. N.Y. State Dep’t of Labor*, 936 F.2d 1448 (2d Cir. 1991); see also *infra* notes 277–285 and accompanying text. See generally Volokh, *supra* note 178, at 963.

210 *Nat’l Collegiate Athletic Ass’n v. Tarkanian*, 488 U.S. 179, 192 (1988); *Jackson v. Metro. Edison Co.*, 419 U.S. 345, 351 (1974).

211 Volokh, *supra* note 178, at 940–41.

212 Metzger, *Privatization*, *supra* note 168, at 1437.

213 Louis Jaffe has identified the importance of a due process analysis in assessing state regulations. Jaffe, *supra* note 194, at 204. See also A. Michael Froomkin, *Wrong Turn in Cyberspace: Using ICANN to Route Around the APA and the Constitution*, 50 DUKE L.J. 17 (2000) (suggesting that the doctrine of forbidding delegation of public powers to private groups is rooted in the Due Process Clause’s prohibition against self-interested regulations); Verkuil, *supra* note 173, at 420.

neutral, non-transparent way²¹⁴—of a kind with traditional due process concerns underlying constitutional law.²¹⁵

As previously mentioned, *Carter Coal*'s decision sounds in due process—that allowing private industry instead of a presumptively disinterested official body to set standards amounts to depriving parties of protected rights and is “so clearly arbitrary, and so clearly a denial of rights safeguarded by the due process clause of the Fifth Amendment.”²¹⁶ Lack of a disinterested decision maker and other government safeguards over the exercise of private power make a delegation suspect. This logic controls in *Sunshine Anthracite Coal Co. v. Adkins*, where the Supreme Court later upheld an amended Bituminous Coal Act against a private non-delegation challenge.²¹⁷ The new version of the Act again allowed private coal boards to set rules governing the sale of coal, which were subject to oversight by the National Bituminous Coal Commission.

However, straightforward due process challenges to the actions of a private hospital will usually meet the barrier of the state action doctrine. The Fifth and Fourteenth Amendments bind only government actors. State action doctrine requires first, that the challenged deprivation must be caused by the exercise of a state-created right or privilege or by a rule of conduct imposed by the state or by a person for whom the state is responsible, and second, that the party charged with the deprivation may “fairly be said to be a state actor.”²¹⁸ Thus, a straightforward due process challenge does not reach the actions of private parties who are not sufficiently supervised by government decision makers. Perversely, the nexus requirement of state action doctrine creates incentives for governments to delegate more unguided powers to private actors to avoid liability.²¹⁹ A facial challenge may be levied more easily where a delegation is standardless and allows private actors to regulate their peers capriciously.²²⁰ In *Washington ex rel. Seattle Title Trust Co. v. Roberge*, the Supreme Court found a violation of due process where property owners “uncontrolled by any

214 See Horton, *supra* note 189.

215 At least one court has suggested that whether a delegation is invalid under non-delegation or due process is purely academic. See Ass'n of Am. R.Rs. v. U.S. Dep't of Transp., 721 F.3d 666, 671 n.3 (D.C. Cir. 2013).

216 *Carter v. Carter Coal Co.*, 298 U.S. 238, 311 (1936).

217 *Sunshine Anthracite Coal Co. v. Adkins*, 310 U.S. 381, 398 (1940).

218 Metzger, *Privatization*, *supra* note 168, at 1412.

219 *Id.* at 1371.

220 *Eubank v. City of Richmond*, 226 U.S. 137 (1912).

standard” may exercise coercive power over other property owners through abstaining or dissenting “for selfish reasons or arbitrarily.”²²¹ The advantage of a due process delegation challenge is that decisions at the Supreme Court bind both state and lower federal courts. Federal non-delegation doctrine does not have binding effect on state legislation, however; it can provide no more than persuasive power. The disadvantage of improper delegation challenges is that finding facial violations of due process on the basis of private third-party veto power are generally disfavored.²²²

Historically, improper delegation to private parties violating the Due Process Clause has been found where a pecuniary bias affects the ability of the private party to be a neutral decision maker.²²³ This principle was articulated in *Eubank v. City of Richmond*, where the Supreme Court invalidated a city ordinance as violating due process where some property owners can “virtually control and dispose of the property rights of others” and may do so “solely for their own interest, or capriciously.”²²⁴ A due process challenge targeting the regulation at issue under the Due Process Clause evaluates the extent of coercive power that the government has delegated to private parties.²²⁵ For the purposes of the following analysis, this due-process-based reasoning will be termed “improper delegation.”

IV. Constitutional Challenges and State Delegation Strategies

A. Past Due Process Challenges to Admitting-Privileges Requirements

Many cases challenging admitting-privileges laws for creating an “undue burden” have also advanced improper delegation challenges.²²⁶ In the early days of admitting-privileges litigation, district courts were receptive to this claim. In Michigan, a regulation

221 *Washington ex rel. Seattle Title Trust Co. v. Roberge*, 278 U.S. 116, 122 (1928).

222 *But see Women’s Med. Prof’l Corp. v. Baird*, 438 F.3d 595, 609 (6th Cir. 2006) (laying out the due process challenge to a private delegation and finding the admitting privileges provision constitutional because the government’s discretionary waiver meant local hospitals do not necessarily hold final say).

223 Volokh, *supra* note 178, at 941.

224 *Eubank*, 226 U.S. at 143. *Eubank* does not quite apply here, because *Eubank* has been interpreted as creating a due process problem where private parties can regulate an unregulated status quo and affect other private rights. Volokh, *supra* note 178, at 942.

225 *See generally* David M. Lawrence, *Private Exercise of Governmental Power*, 61 IND. L.J. 647, 662, 672–95 (1986).

226 Administrative challenges are not a new idea. *See* Gillian Metzger, *Abortion, Equality, and Administrative Regulation*, 36 EMORY L.J. 865, 869 (2007).

requiring abortion clinics to secure a written transfer agreement with a physician who had hospital staff privileges was struck down because the law delegated an “unguided” licensing function to a private entity “whose self-interest could color its decision to assist licensure of a competitor.”²²⁷ The district court stated in no uncertain terms: “The power to prohibit licensure may not constitutionally be placed in the hands of hospitals. Such an impermissible delegation without standards or safeguards to protect against unfairness, arbitrariness or favoritism is void for lack of due process.”²²⁸

More recently, courts have shown ambivalence toward similar challenges, tending to uphold the challenged laws on the basis that some standard or safeguard implicitly exists in the admitting-privileges scheme.²²⁹ The case law reveals, however, that at least some circuits continue to recognize that delegation of an unguided power to issue an effective veto of a license presents a due process problem.

1. Decisions that Recognize a Due Process Problem

Some circuits agree that a due process problem results from giving hospitals unfettered discretion. The most thorough discussion comes from the Sixth Circuit in *Women’s Medical Professional Corporation v. Baird*. *Baird* held that Ohio’s written transfer agreement requirement did not allow hospitals to “essentially grant” a license to an abortion clinic because the regulatory scheme permits a government veto.²³⁰ The court reasoned that, unlike *Roberge*,²³¹ where a minority of landowners could, “uncontrolled by any standard or rule” propounded by the government, affect the rights of their fellows,²³² Ohio’s regulatory scheme grants the Director of the Ohio Department of Health the ability to waive the written transfer agreement requirement. Because area hospitals do not necessarily have

227 *Birth Control Ctrs., Inc. v. Reizen*, 508 F. Supp. 1366, 1375 (E.D. Mich. 1981), *aff’d in part and vacated in part on other grounds*, 743 F.2d 352 (6th Cir. 1984); *see also* *Hallmark Clinic v. N.C. Dep’t of Human Res.*, 380 F. Supp. 1153, 1158 (E.D.N.C. 1974) (holding unconstitutional a written transfer agreement requirement that “placed no limits on the hospital’s decision to grant or withhold a transfer agreement”).

228 *Reizen*, 508 F. Supp at 1375.

229 *See, e.g., Tucson Woman’s Clinic v. Eden*, 379 F.3d 531, 556 (9th Cir. 2004) (finding no evidence to sustain facial challenge to delegation, which requires showing that there are no circumstances under which the delegation could be applied constitutionally).

230 *Women’s Med. Prof’l Corp. v. Baird*, 438 F.3d 595, 609 (6th Cir. 2006).

231 *Washington ex rel. Seattle Title Trust Co. v. Roberge*, 278 U.S. 116 (1928).

232 *Roberge*, 278 U.S. at 121–22.

the final say over a provider's ability to practice, the court found that there was no due process problem.²³³ The Sixth Circuit's decision reversed the district court's holding that the written transfer agreement is unconstitutional as applied to the Dayton clinic because of impermissible delegation, but did not question the applicability of the due process challenge to the delegation.

In upholding Ohio's scheme, the Sixth Circuit looked to a similar Fourth Circuit decision, *Greenville Women's Clinic v. Commissioner, South Carolina Department of Health and Environmental Control*.²³⁴ In *Greenville Women's Clinic*, the state law in dispute required doctors to maintain admitting privileges with a hospital and clinics to maintain referral arrangements with a doctor who has admitting privileges at a local hospital and has agreed to be available during "operating-hours."²³⁵ The Fourth Circuit concluded that the possibility that South Carolina's admitting privileges requirement would amount to a third-party veto of an abortion clinic's license is "so remote that, on a facial challenge, we cannot conclude that the statute denies the abortion clinics due process."²³⁶ The court emphasized that the facial claim failed because no evidence existed to rebut the regulation's constitutionality.²³⁷ The facts were fatal in *Greenville Women's Clinic*: the appellant clinic and doctor had already obtained admitting privileges at local hospitals or arrangements with physicians who had such privileges, in accordance with South Carolina law.²³⁸ A facial challenge could not be sustained without proof that "no set of circumstances" existed under which the Act would be valid, a fact made more unlikely by the existence of a waiver provision.²³⁹

In a footnote, the Sixth Circuit also emphasized that the Fourth Circuit had considered the due process question. South Carolina case law, the Fourth Circuit pointed out, required that the state's "public hospitals not act unreasonably, arbitrarily, capriciously,

233 *Women's Med. Prof'l Corp.*, 438 F.3d at 610.

234 *Greenville Women's Clinic v. Comm'r, S.C. Dep't of Health & Env'tl Control*, 317 F.3d 357, 357 (4th Cir. 2002).

235 *Id.* at 362.

236 *Id.* at 362–63.

237 *Id.*

238 *Id.* at 362.

239 *Id.* at 362–63.

or discriminatorily in granting or denying admitting privileges.”²⁴⁰ The Sixth Circuit did not ultimately find for the clinic in *Women’s Medical Professional Corporation* because the government’s denial of the waiver request was unreviewable. Ohio law granted the Commissioner absolute discretion in deciding whether to approve a waiver request. Thus, the clinic had no property interest in the waiver and no right to due process before the waiver was denied.²⁴¹

2. Decisions Dismissing Due Process Challenges By Analogy to Licenses

Other Courts of Appeals have glossed over the due process problem with a glib analogy to medical licensing schemes. The Eighth Circuit found in *Women’s Health Center of West County, Inc. v. Webster* that Missouri’s requirement that physicians have surgical privileges at local hospitals was no more of a threat to their due process rights than the requirement that abortion providers also be licensed physicians.²⁴² They distinguished contrary precedent because Missouri regulated “the qualifications of persons who perform abortions rather than standards for licensure of abortion clinics.”²⁴³ They buttressed their argument by referring to *Connecticut v. Menillo*, in which the Supreme Court concluded that states may require persons performing abortions to be licensed physicians, to ensure that an abortion is “as safe for the woman as normal childbirth at term.”²⁴⁴

At least one other circuit picked up this analogy. In 2014, the Fifth Circuit quoted *Webster* to reject the unlawful delegation claim against Texas S.B. 2.²⁴⁵ Instead of engaging with the due process question, the Fifth Circuit woodenly recited *Webster*’s analogy comparing admitting-privileges requirements to board licensure requirements.²⁴⁶

240 *Women’s Med. Prof’l Corp. v. Baird*, 438 F.3d 595, 610 n.9 (6th Cir. 2006) (quoting *Greenville Women’s Clinic*, 317 F.3d at 362).

241 *Baird*, 438 F.3d at 615.

242 *Women’s Health Ctr of W. Cnty, Inc. v. Webster*, 871 F.2d 1377, 1382 (8th Cir. 1989).

243 *Id.* at 1382.

244 *Id.* (quoting *Connecticut v. Menillo*, 423 U.S. 9, 11 (1975)).

245 *Planned Parenthood of Greater Tex. Health Servs. v. Abbott*, 748 F.3d 583, 600 (5th Cir. 2014).

246 *Id.*

3. State Licensing Schemes

Webster's analogy, however, is unsound. While state licensing boards must abide by procedural rules that deter arbitrary infringements of a physician's rights, no similar legal mandate governs a hospital's admitting-privileges approval process. Each state defines the qualifications of those permitted to practice medicine, frequently by appointing boards of medical professionals.²⁴⁷ State medical boards follow procedural rules and submit to state regulatory oversight of their decisions, but are generally given deference in their evaluations of a candidate's credentials.²⁴⁸ Greater due process protections cover an already licensed physician if a state board decides to suspend, revoke, or not renew her license, the scope of which are determined by each state's administrative procedure acts.²⁴⁹ Reproductive rights case law demonstrates that although no physician or clinic has a property interest in a license as a first-time applicant, physicians and clinics already in practice have a property interest in the continued operation of their businesses.²⁵⁰

Conversely, because hospitals are generally not state actors, the protections of a state administrative procedure act and constitutional constraints do not apply in judging individual admitting-privileges applications. Hospitals may be required by state law to follow the hospital's own procedural rules, as set forth in their bylaws.²⁵¹ Occasionally, state regulation determines the general process that a hospital's governing body must follow in making determinations about admitting privileges.²⁵² It is only in the latter scenario that the state administrative procedure acts in determine which violations are actionable.

Moreover, transparency issues arise in the admitting-privileges context. Unlike state licensing boards, which are policed by state regulation and whose actions are sometimes subject to disclosure, hospital review processes are not similarly subject to state disclosure regulations. Federal law does not require disclosure of the record in each hospital's

247 Edward P. Richards, *The Police Power and the Regulation of Medical Practice: A Historical Review and Guide For Medical Licensing Board Regulation of Physicians in ERISA-Qualified Managed Care Organizations*, 8 ANNALS HEALTH L. 201, 217–19 (1999).

248 *Id.* at 218–19.

249 *Id.*

250 See *Women's Med. Prof'l Corp. v. Baird*, 438 F.3d 595, 611 (6th Cir. 2006).

251 Discussed *infra* Part IV.C.1.

252 See *infra* Part IV.C.1 for examples.

admitting-privileges decision, while state laws can often protect these records from disclosure.²⁵³

Webster's analogy between state licensing and private admitting-privileges decisions is also overhasty; in areas other than abortion, hospitals can be subject to antitrust suit for effectively pushing a physician out of business.²⁵⁴ The danger of anticompetitive behavior is particularly acute where the hospital may have non-economic interests competing with impartial evaluation of a physician's application. For example, some hospitals are explicitly religious, which creates an additional, First Amendment hurdle for abortion providers to clear. Even when the institution is not religious, a hospital's review board must struggle with religious, moral, and economic concerns in associating with a doctor who provides abortions, concerns not triggered by a state board's mere grant or renewal of this doctor's license. This due process problem is exacerbated where state law lacks any standards, principles, or mechanisms protecting against private arbitrariness or favoritism.²⁵⁵

For the analogy between hospitals and state licensing boards to be valid, similar due process protections must inhere in the hospitals' decision making. First, pecuniary interest in the proceedings can make a party an improper decision maker with respect to licenses.²⁵⁶ A state board biased by "prejudgment and pecuniary interest" cannot constitutionally revoke a doctor's license.²⁵⁷ While traditionally framed in an antitrust light, this prohibition can also include hospitals motivated by fear of losing donors and patients due to publicity around granting privileges to an abortion provider. Under this theory, a law that empowers a hospital biased by financial interest or other prejudgment to effectively revoke a previously valid license is constitutionally suspect.

Otherwise, the state could exploit the private prejudice of hospitals to evade the application of the state action doctrine, effectively reducing women's access to abortion through the private acts that fall outside the reach of state action doctrine. For example, in the *Currier* case, not only did a state legislator boast to constituents about the law, emphasizing the difficulty of obtaining admitting privileges, state counsel also did not contest that Mississippi's Attorney General aimed to shut down the state's sole licensed

253 See *supra* note 83.

254 See *supra* note 82.

255 *Group Health Ins. of N.J. v. Howell*, 40 N.J. 436, 447 (1963).

256 See *Tumey v. Ohio*, 273 U.S. 510, 523–24 (1927); see generally Volokh, *supra* note 178.

257 *Gibson v. Berryhill*, 411 U.S. 564, 578 (1973).

clinic.²⁵⁸ All seven hospitals in the area had in fact refused to grant doctors admitting privileges. Responses to the clinic's request included: "[t]he nature of your proposed medical practice is inconsistent with this Hospital's policies and practices as concerns abortion and, in particular, elective abortion," and "[t]he nature of your proposed medical practice would lead to both an internal and external disruption of the Hospital's function and business within this community."²⁵⁹ The State subsequently denied the clinic's request for a waiver.²⁶⁰

B. The Future of Improper Delegation Challenges

More recently, with the spate of new admitting-privileges laws being passed, some district courts have evinced openness to challenges on the basis of a due process violation amounting to improper delegation. In Mississippi, plaintiffs expressly reserved the claim of improper delegation of lawmaking authority, which the court suggested could be a valid argument.²⁶¹ In Alabama, the improper delegation claim was dismissed without prejudice because neither party had presented a regulation promulgated to enforce Alabama's admitting-privileges requirement.²⁶²

Just last year, the district court in Wisconsin found an unconstitutional delegation where the state law implements a requirement from hospitals that doctors applying for admitting privileges have a record of "inpatient care."²⁶³ Such a requirement served "no legitimate state interest" and, in the absence of a statutory mechanism by which the government can waive the admitting privileges requirements, cannot constitutionally be imposed on abortion providers.²⁶⁴ The success on the merits in Wisconsin demonstrates that improper delegation remains an open, if relatively underused, avenue to pose constitutional challenge against admitting-privileges laws.

258 Jackson Women's Health Org. v. Currier, 940 F. Supp. 2d 416, 423 (S.D. Miss. 2013).

259 *Id.* at 450 n.3.

260 *Id.* at 450–51.

261 Jackson Women's Health Org. v. Currier, 940 F. Supp. 2d 416, 420 n.2 (S.D. Miss. 2013) (granting preliminary injunction).

262 Planned Parenthood Se., Inc. v. Strange, 9 F. Supp. 3d 1272, 1278–79 (M.D. Ala. 2014).

263 Planned Parenthood of Wis. Inc. v. Van Hollen, 94 F. Supp. 3d 949, 996–97 (W.D. Wis. 2015).

264 *Id.*

C. Other Strategies

1. State Administrative Processes

Straightforward state administrative challenges also exist to challenge admitting-privileges laws.²⁶⁵ Most state codes contain administrative processes by which an regulated party can contest enforcement or penalty actions brought by the State.²⁶⁶ However, few states provide preemptory administrative methods to prevent a medical license revocation due to inability to obtain admitting-privileges.

In this Section, I give brief samples of different types of state administrative processes, as a fifty-state survey is beyond the scope of this Note. Alabama regulations require that a hospital's bylaws include criteria for determining the privileges to be granted to individual physicians and a procedure for applying the criteria to individuals requesting privileges, but does not provide for external review of either the criteria or procedure.²⁶⁷ Tennessee regulations require hospital bylaws to contain procedures governing the grant, revocation, suspension, and renewal of medical staff privileges, including an appeal process.²⁶⁸ Outside of these bylaw procedures, no state process or supervision is mandated during the physician's admitting-privilege application proceedings.

Although Texas regulations lack an administrative waiver of the admitting-privileges requirement,²⁶⁹ the governing bodies of hospitals must ensure that each physician is afforded procedural due process in his or her application for medical staff privileges by state regulation.²⁷⁰ Hospitals that fail to take the required action on a completed application can be brought to mediation by the affected physician as provided for under Texas' Civil

265 Advocates increasingly turn to administrative complaints in recent years. In the absence of judicial review (whether due to lack of standing, a viable cause of action, or other barriers), administrative complaints have increasingly been used either as direct enforcement strategy leading to voluntary compliance agreements, or as a strategic adjunct to community outreach and grassroots campaigning.

266 See, e.g., MISS. CODE ANN. § 41-75-13 (West 2014); ARIZ. ADMIN. CODE. §§ 36-431.01, 36-427, 36-430 (West 2014); 25 TEX. ADMIN. CODE § 139.53 (West 2014).

267 See, e.g., ALA. ADMIN. CODE r. 420-5-7-.09 (West 2015).

268 TENN. COMP. R. & REGS. 1200-08-01-.06(2)(b), (2)(d) (West 2014).

269 25 TEX. ADMIN CODE § 139.53 (2014).

270 25 TEX. ADMIN CODE § 133.41(f)(4)(F)(i) (2014).

Practice and Remedies Code § 154.052, and within a reasonable period of time.²⁷¹ However, no cause of action exists against the hospital other than to require the hospital to participate in mediation.²⁷²

Ohio, one of the few states providing pre-enforcement remedies, empowered the director of the state health department to grant a variance or waiver from any building or safety requirement established by the code that governed abortion facilities and physicians.²⁷³ The waiver process provided a (theoretical) bypass for providers to practice despite admitting-privileges denials.

In Mississippi, the state is not directly authorized by code to grant waivers of the license requirement.²⁷⁴ The Mississippi law requires that doctors have admitting privileges not only to operate currently open clinics but upon an application for a clinic license.²⁷⁵ Licenses can be suspended after notice and a hearing where the agency finds a substantial failure to comply with abortion and ambulatory surgical center requirements; suspensions and other adverse decisions may be judicially challenged.²⁷⁶ Under state law, a Mississippi hospital's decision to grant staff privileges is subject only to review of whether the hospital had followed its own bylaw requirements of due process.²⁷⁷

The fact that few states provide administrative methods to bring pre-enforcement challenges to a hospital's decision makes it difficult to challenge area hospitals' denial of staff privileges without voluntarily violating the state regulation. This can be a huge disincentive to physicians, whose medical licenses are at risk when they violate state regulations.

271 § 133.41(f)(4)(F)(i)(VIII).

272 § 133.41(f)(4)(F)(i)(II).

273 OHIO ADMIN. CODE 3701-83-14 (West 2015).

274 See MISS. CODE ANN. § 41-75-5 (2014). The district court also noted that Mississippi's regulation does not allow waivers. *Jackson Women's Health Org. v. Currier*, 940 F. Supp. 2d 416, 420 n.2 (S.D. Miss. 2013).

275 MISS. CODE ANN. § 41-75-1 (2014).

276 MISS. CODE ANN. § 41-75-11 (2014). The applicant is free to appeal a denial, revocation, or suspension of a license to the chancery court in the county. *Id.*; MISS CODE ANN. § 41-75-23 (2014).

277 *Wong v. Garden Park Cmty Hosp., Inc.*, 565 So.2d 550 (Miss. 1990). See also MISS. CODE ANN. § 73-25-93 (2014).

2. Litigation Under State Non-Delegation Doctrines

More unconventionally, an improper delegation could be attacked under the framework of each state's private delegation doctrines.²⁷⁸ Some states have more detailed private delegation analysis that may give greater protections. Texas, for example, requires that courts more closely examine private delegations than public delegations.²⁷⁹ It instituted an eight-factor test. First, the court will consider whether the private delegate's actions are subject to meaningful review by a state agency or other branch of state government.²⁸⁰ Second, it weighs whether the persons affected by the private delegate's actions are adequately represented in the decision-making process.²⁸¹ Third, it considers whether the private delegate's power is limited to making rules, or whether the delegate also applies the law to particular individuals.²⁸² Fourth, it assesses whether the private delegate has a pecuniary or other personal interest that may conflict with his or her public function.²⁸³ Fifth, it examines whether the private delegate is empowered to define criminal acts or impose criminal sanctions.²⁸⁴ Sixth, it accounts for whether the delegation is narrow in duration, extent, and subject matter.²⁸⁵ Seventh, it examines whether the private delegate possesses special qualifications or training for the task delegated to it.²⁸⁶ Lastly, it looks to whether the legislature has provided sufficient standards to guide the private delegate in his or her work.²⁸⁷

Theoretically, an application of these eight factors could weigh very strongly against a state law granting an effective license to private hospitals. Although hospitals have greater expertise (the seventh factor), they also have pecuniary and other ethical or personal interests that may conflict with the function of carefully assessing a physician (fourth factor). There

278 See *supra* Part II.1.

279 Tex. Boll Weevil Eradication Found., Inc. v. Lewellen, 952 S.W.2d 454, 469 (Tex. 1997).

280 *Id.* at 472.

281 *Id.*

282 *Id.*

283 *Id.*

284 *Id.*

285 Tex. Boll Weevil Eradication Found., Inc. v. Lewellen, 952 S.W.2d 454, 472 (Tex. 1997)

286 *Id.*

287 *Id.*

is no indication that these physicians have representatives in the decision-making process either (second factor), and the delegation is arguably lengthy in duration, as the power to make an admitting-privileges decision has lasting impacts beyond the few months which it takes to come to a decision (sixth factor). Furthermore, there is little indication that the legislature had given hospitals any guidance (eighth factor).

This application of Texas's private delegation doctrine is, of course, purely theoretical and necessarily cursory. This strategy has inevitable downsides: if the claim is brought in state courts, state judges and juries may be no more inclined to mitigate the effects of state regulation than the government.

Yet case law reveals that some state courts are open to protecting the interests of abortion providers and women seeking abortion. In Oklahoma, the state supreme court unanimously voted to enjoin two laws that were set to take effect in November 2014—one of which required a physician with admitting privileges at a local hospital to be present during abortions.²⁸⁸ In that case, a doctor had testified at trial that he performs more than forty percent of the abortions in the state, that he had been unable to obtain admitting privileges in hospitals near his clinic, and that enforcement of the admitting privileges law would cause him to shut down his practice.²⁸⁹ Likewise, Tennessee's recent constitutional amendment was a response to a Tennessee Supreme Court case giving greater substantive due process protections to abortion in that state than federal law would have provided.²⁹⁰

3. Church Amendments, Federal Administrative Advocacy,²⁹¹ and Qui Tam Suits

Under the Church Amendments, a federally-funded hospital cannot deny an otherwise qualified applicant admitting privileges based on the applicant's status as an abortion

288 Timothy Williams, *Oklahoma Supreme Court Blocks Two Abortion Laws*, N.Y. TIMES (Nov. 4, 2014) http://www.nytimes.com/2014/11/05/us/oklahoma-supreme-court-blocks-2-abortion-laws.html?_r=0 [http://perma.cc/A62E-EP7L].

289 *Id.*

290 *See supra* notes 48–49.

291 For a discussion of advocacy through administrative processes at the federal level, see Jessica Rubin-Wills, *Language Access Advocacy After Sandoval: A Case Study of Administrative Enforcement Outside the Shadow of Judicial Review*, 36 N.Y.U. REV. L. & SOC. CHANGE 465 (2012). For a thorough account of the multifaceted work of law reform through administrative mechanisms, see Olatunde C.A. Johnson, *Lawyering That Has No Name: Title VI and the Meaning of Private Enforcement*, 66 STAN. L. REV. 1293, 1311–31 (2014).

provider.²⁹² Yet, courts consistently refuse to imply a right of action to enforce the Church Amendments.²⁹³ Instead, the U.S. Department of Health and Human Services (HHS) has previously enforced the Amendments through investigations and voluntary compliance orders. So far, available data on Church Amendment enforcement shows that the Office of Civil Rights (OCR) has resolved a case surrounding the conscience rights of two applicants to Vanderbilt University's nurse residency program.²⁹⁴ No investigation or voluntary compliance agreement involving admitting-privileges denials has been publicized. Theoretically, the OCR may investigate a hospital's denial of admitting privileges on the basis of abortion provision. The investigation could lead to a compliance agreement going forward.

Admittedly, reliance on HHS-conducted investigations is not ideal. Limited government resources, the difficulty of proving improper motives, and internal politics are a few of a litany of reasons why the OCR might not pursue a particular case of admitting-privileges denial. Plus, the temporary nature of pregnancy and the urgency that inheres in abortion services can make the lengthy administrative complaint process unsuitable as a primary method of securing women's rights of access to abortion.

On the other hand, HHS is a major policy maker in the health care landscape, through both its released guidance and more informal methods by which it pushes public health issues.²⁹⁵ Legal advocacy for agency action can supplement more pressing litigation addressed toward admitting-privileges laws. Advocating for developed guidance around an aspect of the Church Amendments could become a political fuse igniting counter-advocacy on the part of pro-life organizations to more rigidly promote the conscience protections that they embody. However, the piecemeal reproductive rights struggle—as litigation is won or

292 Akbar Ahmed, *Hospitals Can't Deny Admitting Privileges to Abortion Doctors, AG says*, J. SENTINEL (Aug. 7, 2013), <http://www.jsonline.com/news/statepolitics/wisconsin-attorney-general-says-hospitals-cant-deny-admitting-privileges-to-abortion-doctors-b997046-218608951.html> [<http://perma.cc/VBC3-637A>].

293 See *Cenzon-Decarlo v. Mount Sinai Hosp.*, No. 09 CV 3120(RJD), 2010 WL 169485 (E.D.N.Y. Jan. 15, 2010), *aff'd*, 626 F.3d 695 (2d Cir. 2010); *Nead v. Bd. of Trs. of E. Ill. Univ.*, No. 05-2137, 2006 WL 1582454 (C.D. Ill. Jun. 6, 2006). The lack of a private right of action also carries the benefit of foreclosing time- and resource-consuming conscience-based suits. See generally Nathaniel James, *The Church Amendment: In Search of Enforcement*, 68 WASH. & LEE L. REV. 717 (2011).

294 Powerpoint, *Enforcement of the Federal Health Care Provider Conscience Protection Laws*, U.S. DEP'T HEALTH & HUMAN SERVS, http://akatest3-ion-www.hhs.gov.edgekey-staging.net/sites/default/files/ocr/civilrights/provider_conscience_ppt.pdf [<https://perma.cc/4UXC-27H4>].

295 Among its current publications are Informed Consent Requirements from OHCP and model documents such as Model Notices of Privacy Practices.

lost on sensitive, state-specific fact patterns—can benefit from HHS setting a nationwide policy that may help standardize and make transparent hospitals' and state administrators' decision-making processes.

Another option is the *qui tam* suit,²⁹⁶ in which a private citizen brings suit under the False Claims Act against persons who presented false claims for payment to, or otherwise defrauded, the Federal treasury.²⁹⁷ In *qui tam* actions, the plaintiff does not defend a private right, but the interest of the public in general in place of the government, to enforce a policy explicitly formulated by legislation.²⁹⁸ Under this theory, when a hospital violates employment nondiscrimination conditions attached to their receipt of federal funding by refusing a physician's application for admitting privileges because they provide abortion,²⁹⁹ an injured physician may bring a *qui tam* suit for damages against the hospital. *Qui tam* suits are not without disadvantages. First, the False Claims Act authorizes a damages remedy, not injunctive relief.³⁰⁰ This may be cold comfort to the physician whose livelihood has been eliminated and whose patients might not be able to access abortions. The government may also intervene in the action, and moreover may settle the suit with the defendant after a hearing or even terminate the action, regardless of the preferences of the plaintiff.³⁰¹ However, the plaintiff's incomplete control over the proceedings is counterbalanced by the government's attention and, with it, governmental resources that may be available for the action.³⁰²

296 See generally David Freeman Engstrom, *Harnessing the Private Attorney General Evidence from Qui Tam Litigation*, 112 COLUM. L. REV. 1244 (2012).

297 Evan Caminker, *The Constitutionality of Qui Tam Actions*, 99 YALE L.J. 341, 343 (1989).

298 *Id.* at 345 (quoting *Priebe & Sons v. United States*, 332 U.S. 407, 418 (1947) (Frankfurter, J., dissenting)).

299 In the case of the Church Amendments, these conditions extend to the Public Health Service Act, 42 U.S.C. §§ 201–300mm (2012), the Community Mental Health Centers Act, 42 U.S.C. § 2689 (2012), and the Developmental Disabilities Services and Facilities Construction Act, 42 U.S.C. §§ 6000–81 (2012). 42 U.S.C. § 300a-7(c) (2012).

300 31 U.S.C. § 3729(a) (2012).

301 Michael R. Dorfman, *Qui Tam: Fighting the Uphill Battle Against Health Care Fraud*, 77 U. DET. MERCY L. REV. 927, 938 (2000).

302 *Id.* at 940.

CONCLUSION

Regardless of abortion's legality, demand persists.³⁰³ Increasing restrictions on women's access to abortion due to state laws correlates with the growth of a black-market economy in abortion drugs.³⁰⁴ A woman faced with dwindling options may resort to taking these drugs without proper instruction or supervision, leading to health complications.³⁰⁵ TRAP laws thus perversely foreclose one of safest paths available to women to ensure their own bodily and decisional autonomy.

Reproductive rights advocacy is more urgent than ever. Testimony from obstetrician- and gynecology-certified physicians and the managers of Whole Women's Health revealed that the admitting-privileges provision has the effect of preventing at least 22,286 women annually from procuring an abortion.³⁰⁶ Aside from the direct effects of these TRAP laws, a culture of shaming from hospitals can deter new doctors from entering this line of work. Of several doctors who had worked with Whole Women's Health before, two were not interested in joining the clinic due to fear that "future changes in the law would make it impossible to provide abortions in the state"; another because he feared that involving himself in abortion would cost his future obstetrics practice; another operated at a Catholic hospital which directed the doctor to stop speaking to Whole Women's Health and eventually fired him; and another concluded that obtaining admitting privileges would be impossible given the caseload requirements at one of the local hospitals, while the other is a Catholic hospital that declines to grant admitting privileges on the basis of an applicant's association with abortion practice.³⁰⁷ These testimonies show that the admitting-privileges requirement deploys nongovernmental social and economic pressures to create barriers to becoming or remaining an abortion provider.

303 See Elisabeth Rosenthal, *Legal or Not, Abortion Rates Compare*, N.Y. TIMES (Oct. 12, 2007), http://www.nytimes.com/2007/10/12/world/12abortion.html?_r=0 [<http://perma.cc/HDC3-8AGW>].

304 See, e.g., Erica Hellerstein, *The Rise of DIY Abortion in Texas*, ATLANTIC (June 27, 2014, 9:00 AM), <http://www.theatlantic.com/health/archive/2014/06/the-rise-of-the-diy-abortion-in-texas/373240/> [<http://perma.cc/A3K4-XNR5>]; Fiona Keating, *Black Market Abortion Drugs Trade Increases as US Clinics Close at Record Rate*, IBTIMES (Jan. 18, 2015 6:04 PM), <http://www.ibtimes.co.uk/black-market-abortion-drugs-trade-increases-us-clinics-close-record-rate-1483975> [<http://perma.cc/8LTA-GCXX>].

305 Esme E. Duprez, *Legal Abortions Made Harder, Texans Turn to Flea Market Pills*, BLOOMBERG (July 11, 2013 5:17 PM), <http://www.bloomberg.com/news/2013-07-11/flea-market-abortion-thrive-as-texas-may-close-clinics.html> [<http://perma.cc/SK26-PGUV>].

306 *Planned Parenthood of Greater Tex. Health Servs. v. Abbott*, 748 F.3d 583, 591 (5th Cir. 2014).

307 *Id.* at 591–93.

As passage of restrictive state regulations accelerates, the undue burden standard is being applied in district and circuit courts around the country.³⁰⁸ Its track record, however, is troubling. While in certain cases the standard remains a powerful tool to protect women's autonomy,³⁰⁹ all too often the standard provides little guidance to courts, resulting in inconsistent outcomes. As of the date of this printing, *Whole Woman's Health* has been argued in the Supreme Court, with numerous amici on both sides offering divergent and even contradictory views to the conversation.³¹⁰ The case presents an opportunity not only for the Court to reaffirm the balance between the state's interest in regulating medical procedures and a woman's right to choose an abortion, but to clarify the the undue burden standard.³¹¹

As it stands, "undue burden" is not the only tool we have. In this Note, I have proposed four additional methods of challenging admitting-privileges decisions, focusing mainly on a constitutional attack of improper delegation violating the Due Process Clause. Legal advocates considering strategies to defend against overly burdensome abortion regulations may benefit from a close consideration of whether these tactics might be useful in their particular circumstances.

308 Paige Winnfield Cunningham, *Courts Wrestle with Wave of New State Abortion Laws*, POLITICO (Jan. 8, 2015), <http://www.politico.com/story/2015/01/courts-state-abortion-laws-114068.html> [<http://perma.cc/8NBW-XJGA>].

309 See, e.g., *Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908, 908 (7th Cir. 2015).

310 See *Whole Woman's Health v. Hellerstedt*, SCOTUSBLOG, <http://www.scotusblog.com/case-files/cases/whole-womans-health-v-cole/> [<https://perma.cc/TZR9-JW5J>] (last visited Feb. 20, 2015).

311 See Gillian Metzger, *Symposium: Hanging in the Balance*, SCOTUSBLOG (Jan. 6, 2016, 9:23 AM), <http://www.scotusblog.com/2016/01/symposium-hanging-in-the-balance/> [<https://perma.cc/SW23-8HCR>] ("If [a seventy-five percent closure rate statewide and a one-hundred-percent closure rate for all clinics south and west of San Antonio] do not constitute a substantial obstacle for women seeking abortions, the concept of substantial obstacle has no recognizable meaning.").